“Why are you crying? You got what you wanted!”

Psychosocial experiences of sex reassignment surgery.

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Submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

Faculty of Health

Queensland University of Technology

2016

Keywords

Corporeality, embodiment, gender dysphoria, gender identity disorder, human rights, loss and grief, mental health, narrative inquiry, nursing, psychotherapy, psychosocial, qualitative research, sex reassignment surgery, social constructionism, standards of care, stigma, transgender, transsexual, transsexualism, visual methodologies.

Abstract

Gender Dysphoria (GD) has been estimated to occur in approximately 1.4% of the world's population and is problematically recognised as a mental disorder where individuals can possibly experience extreme distress associated with living in their biological gender. Sex reassignment surgery (SRS) is experienced by some people diagnosed with GD as a medically necessary treatment and is recognised as a successful treatment for the majority of trans* people who pursue that option. Despite knowledge of the long term outcomes of the surgery and their mostly positive effects on social functioning, satisfaction and quality of life, little is known about the psychosocial needs of trans* individuals as they make the surgical transition to their preferred gender. This qualitative study explored the lived experiences of 14 Australian trans* men and women, aged between 25 and 78 who had undergone SRS to determine if their needs were met.

Underpinned by a theoretical framework derived from social constructionism, embodiment and narrative, the data were generated through participant produced drawings and unstructured interviews and analysed by employing a 'narrative border' framework. Four narrative concepts emerged from the data and are concerned with navigating the personal self, the social self, the medical self and the legal self. The key analytical findings suggest that while the surgery met the personal needs of the participants, there are inconsistencies in the level of care and support provided at the medical level throughout the transition process. While in legal terms, the complex

legislative framework does little but increase the psychosocial burden of trans* people in Australia.

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List of Abbreviations

ADF	Australian Defence Forces
ANZPATH	Australian and New Zealand Professional Association for Transgender Health
APA	American Psychiatric Association
ATSAQ	Australian Transgender Support Association of Queensland (Inc.)
CCEI	Crown Crisp Experiential Index
COAG	Council of Australian Governments
COAR	Council of Australian Registrars
CYP19	Aromatase Gene
DSD	Disorder of Sex Development
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition
DSM-III-TR	Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition Text Revised
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revised
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
ERβ	Estrogen Receptor β Gene
FTM/FtM	Female to Male
GD	Gender Dysphoria
GI	Gender Incongruence

GIAA	Gender Identity Awareness Association
GID	Gender Identity Disorder
GIDAANT	Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type
HBIGDA	Harry Benjamin International Gender Dysphoria Association
HREC	Human Research Ethics Committee
ICD	International Classification of Diseases
LGBT	Lesbian Gay Bisexual Transgender
LGBTI	Lesbian Gay Bisexual Transgender Intersex
MTF	Male to Female
MGOV	Many Genders, One Voice
NHMRC	National Health and Medical Research Council
NP	Nurse Practitioner
QUT	Queensland University of Technology
RLE	Real-life Experience
SOC	Standards of Care
SRS	Sex Reassignment Surgery
WHO	World Health Organisation
WPATH	World Professional Association for Transgender Health

Conference Presentations

Chaplin, B. (2012). Sex reassignment surgery: Panacea, placebo or Pandora's Box? – A narrative inquiry. *Presented at the Queensland Transgender, Sistergirl and Gender Diverse Conference in Cairns, Australia, August 24-25, 2012.* (Oral)

Chaplin, B., Cox, L., & Campbell, C. (2014). An overview of Australian intrans*igence – A systemic Pandora's Box. *Presented at the WPATH Symposium: Transgender Health from Global Perspectives in Bangkok, Thailand, February 14-18, 2014.* (Oral)

Chaplin, B., Cox, L., & Campbell, C. (2014). "Blokes don't cry, so man up" – A trans*gressive life in Queensland jails. *Presented at the WPATH Symposium: Transgender Health from Global Perspectives in Bangkok, Thailand, February 14-18, 2014.* (Oral)

Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

QUT Verified Signature

Signature:

15/03/16

Date: _____

Acknowledgements

> Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful [sic] execution; it represents the wise choice of many alternatives. William A. Foster (1917-1945)

William A. Foster's words have been a constant reminder in my life since 2010 when they came across my desk serendipitously through a dear colleague of mine, Geraldine Horan. Thanks Gerry. I hope that the socially constructed body of work that follows reflects Foster's views. This thesis is a collaborative effort that would not have been possible without the assistance, perseverance, encouragement, foresight and intellectual acumen of those around me.

Firstly, I need to pay eternal thanks to my academic supervisors, Dr Leonie Cox and Dr Christina Campbell (affectionately known as LC and CC) for their guidance throughout this PhD journey. At times when I was going off the rails, they were my rocks and mostly managed to keep me focused, despite my meandering down some very muddy lanes. There were times I refused to be managed but they remained there in the background, occasionally prodding me in the right direction. Their depth of research knowledge, although not specifically in my area of research, was and is greatly appreciated, and I don't think I could have endured this journey along some of those very muddy lanes without them. They are indeed special ladies and I have enjoyed my unique relationship with them.

Secondly, to the many trans* support organisations around Australia that assisted me in recruiting the participants for this study. I especially

would like to thank the many wonderful members of Many Genders, One Voice (MGOV), a sex and gender diverse health action group operating in Brisbane under the auspices of Queensland Aids Council (formerly the Queensland Association of Healthy Communities), who assisted me in ensuring my language in the many facets of this research, was appropriate and inclusive.

[1]

This research could not have been undertaken without the 14 trans* men and women who graciously participated and not only openly spoke of their many and varied experiences, but accepted me without hesitation into their lives and to form the relationships I did with them. It can sometimes be difficult to talk about parts of our lives that are deeply personal, but they all did that openly, honestly and with conviction for the reason that they care what actually happens to trans* people in this country.

Thanks must also go to my wonderful QUT peers and colleagues who get a giggle out of my jokes and trivia. Connecting with you all has been a very satisfying part of my journey and hopefully helped us all remain sane when that kairotic moment lets us 'smell the roses' once in a while. I wish you all success in your own research journeys. Equally important, to QUT itself for making it possible to research a topic that has been neglected in

[1] Permission to use this image is located at Appendix A.

Australia for long enough and to the Australian Government for providing me with financial support by granting me an Australian Postgraduate Award Scholarship, without which I would not have been able to pursue this course of study.

To my ex-partner Glenn, thank you. I met Glenn just before I began this rollercoaster journey. His love of my 'quirkiness' (which I didn't appreciate nearly enough as I should) and his perseverance with my moodiness was another rock in my life. I thank him deeply for his belief in my ability to succeed, but more importantly for his friendship and being an enormous part of my world. Sorry we didn't make it. "Crikey Mikey!"

Sadly, I need to acknowledge the passing of a very dear friend and trans* advocate, Kathy Anne Noble (20th December, 1934 – 17th August, 2015), who appears throughout this document in her personal communications to me. Kathy worked tirelessly fighting for the global trans* community in many areas of concern. I dare say the likes of her will never be replaced. VALE Kathy.

And finally, I need to thank 'the universe' for giving me this fabulous gift of life as a trans* woman. I feel truly honoured to have led the majority of my life in this body so estranged from my natal biology and to be given the opportunity to be involved in making a difference for my community – the trans* community. I can honestly say 'I've looked at life from both sides now' on so many levels.

Dedication

This work is dedicated to Adele Bailey, a postoperative[2] trans* woman prostitute, who was brutally murdered at the young age of 32 and her body dumped in a deserted Victorian mineshaft in 1978. Adele, a friend of mine, was a kind, peaceful soul who was killed for no better reason than the fact that she was a trans* woman. Her killer has never been brought to justice. Adele is but one of the thousands of trans* people in the world who have been ruthlessly murdered for being a trans* or gender diverse individual, and this work is dedicated in part to all those destroyed souls.

[2] Postoperative refers to someone who has undergone sex reassignment surgery (SRS).

Chapter 1: Introduction

> Admittedly, the world contains masculine men, and feminine women, but these categories are not exhaustive, exception-less, immutable, or clearly defined. (McKitrick, 2007, p. 147)

"Why are you crying? You got what you wanted!" which features in the title of this thesis are words spoken by a plastic surgeon to Dee Dee,[3] a trans*[4] woman participant who had undergone a vaginoplasty the previous day. At the time of her interview for this research, Dee Dee remembers crying and being in a significant amount of pain following the surgery but those words by the surgeon shocked and angered Dee Dee. Her response to the surgeon was "I don't know."

That small excerpt of dialogue highlights the focus of this qualitative research. Undergoing such radical surgery, although anticipated, wanted and indeed needed, is a complex biopsychosocial phenomenon for those undergoing the procedure. Although such surgeries have been conducted with success for many decades, surprisingly little is known on the psychosocial needs of individuals such as Dee Dee as they transition surgically.

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[3] It is an opportune time to remind any reader that in the interests of participant confidentiality and anonymity, each participant was asked to choose a pseudonym for use in this thesis.

[4] Labelling people who identify outside the binary gender framework (male or female) is a constant source of concern for this researcher and for those who wish to be labelled or not. Some words which are often used to identify trans* and gender nonconforming people include but are not limited to transsexual, transgender, gender diverse, male to female (MTF), female to male (FTM), trans* woman, trans* man, drag queen, drag king, cross-dresser, transvestite, genderqueer and so on. For the major component of this discussion, I have chosen to use the term 'trans*' purely for the purposes of being consistent. Trans* is also a term used in modern language. Other terms may be used when referring to specific people who identify in a particular way or to be true to the literature from which it is derived.

Gender dysphoria (GD), formerly known as Gender Identity Disorder (GID) and Transsexualism is a term used to describe the potentially extreme distress that is experienced when an individual is not comfortable with their biological gender (American Psychiatric Association, 2013). For trans* people, a psychiatric diagnosis of GD can result in several possible treatment options including hormone therapy, surgery and/or psychotherapy to explore the most appropriate outcome for that particular person. Each of these treatment options should be considered as producing valid outcomes. For some trans* people such as myself and Dee Dee, permanent physical transformation is required to alleviate GD and this treatment option is known as sex reassignment surgery (SRS).[5]

Guidelines on the care, health and wellbeing of trans* people have existed since 1979 and are in a continual state of evolution. These Standards of Care (SOC) (WPATH, 2011a) include the care of those trans* people assessed as suitable for surgical transition. Through interviewing trans* people who have undergone SRS, this study explored the surgical process and sought to understand the psychosocial needs of its participants as they navigated surgical transition to their preferred gender. Additionally, this study explored the relationship between the perceived needs of trans* people and the SOC with a view to suggesting enhancements to the SOC in order to reflect those needs. Finally, this study explored the relationship

[5] I have chosen the terminology sex reassignment surgery (SRS) to use throughout this document for consistency and to comply with the terminology used in the Standards of Care [Version 7] (WPATH, 2011a). Some other terms are often used in the literature to describe the surgery including gender confirmation surgery, genital reconstruction surgery, sex affirmation surgery, genital reassignment surgery, gender affirmation surgery and sex change. A detailed definition as it relates to this study is located on page 31.

between the needs of trans* people and the Australian legislative framework as it applies to the legal status of those undergoing SRS.

In this introductory chapter, I begin with a brief snapshot of the 'sex change' operation in the 20th century and introduce the problematic psychopathologisation of the trans* phenomenon. I trace the history of GD from its roots as a psychosexual disorder in the DSM.[6] An estimate of the numbers of gender variant[7] people globally and in Australia is presented in order to contextualise the significance of this growing area of concern and the need for continued research in this area, which is followed by a discussion of the current thinking on GD's aetiology. I then discuss the context of this research. Following this, I overview the research which inspired me to pursue this study and outline my personal interest in this field of work, followed by the study's aims and objectives. I then provide gendered definitions of SRS, which underpinned the selection of participants for this study. Finally, the structure of this thesis will be outlined.

1.1 'SEX CHANGE'

1.1.1 An historical context: the modern era

For those individuals who traverse the process of gender reassignment, the final physical step in the transition involves undertaking SRS, an irreversible medical procedure. In the modern era, the first documented 'sex change' operation occurred in the USA in 1917 (Gilbert, 1920, p. 298). A

[6] The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association is a classification system of mental disorders used by mental health practitioners as a practical guide using standardised diagnostic criteria.

[7] An individual's gender identity or expression which differs from socially and culturally accepted norms – not synonymous with gender dysphoria.

female medical doctor from an “apparently normal” family background presented for treatment at Gilbert’s practice, which Gilbert (1920, p. 297) referred to as a treatment for homosexuality. According to Gilbert (1920, p. 317), following a psychoanalytic assessment and physical examination, the patient known as H, transitioned to male after a hysterectomy was performed.

Following on from this initial episode, the next surgical reassignment[8] surgeries recorded were in Europe in 1931 on those termed “male transvestites” (Abraham, 1931/1997). As reported by Abraham (1931/1997), these ‘emergency’ surgeries were performed to prevent self-harm through bodily mutilation of the ‘offending’ organs. The rather crude but revolutionary surgery involved castration, amputation and rudimentary fashioning of a vaginal organ below the scrotum using skin grafts from the upper thigh area.

However, it was not until the 1950s[9] that the first publicly reported ‘sex change’ operation of Christina Jorgensen brought this phenomenon into public consciousness through sensationalist articles in the New York Times (Sørensen & Hertoft, 1980). For Beemer (1996), it is Jorgensen’s identity that remains a significant event in the lives of some trans* people. Interestingly enough, it was originally intended that her operation was intended as a cure for her assumed homosexuality (Sørensen & Hertoft, 1980), which was later refuted when Hamburger, Stürup and Dahl-Iversen (1953) described the procedure.

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[8] In the interim period between 1917 and 1931, the first surgery in the modern era on a hermaphrodite (now known as intersex) was performed in Germany (Kaufmann, 2010), although surgical reassignment of hermaphrodites existed much earlier (Warren, 2014).

[9] Christina Jorgensen, although not the first to have sex reassignment surgery (SRS), was popularly renowned as being the first person to undergo the operation in 1951.

Other pioneering trans* women such as Carlotta in Australia, April Ashley from the United Kingdom and others raised the public profile of postoperative trans* women throughout the second half of the 20th century through their celebrity status. For example, Carlotta is renowned in Australia as one of the original members of Les Girls,[10] a television star and author (Carlotta, 2012). April Ashley[11] received an MBE from Queen Elizabeth II for her pioneering work in transgender equality and recognition of her contribution over many decades (BBC News Liverpool, 2012, December 13). The procedure grew in popularity globally following the publication of Jorgensen's surgery (Sørensen & Hertoft, 1980) and surgical techniques improved for trans* women over time (Eldh, Berg, & Gustafsson, 1997).

Eldh et al. (1997) described two separate techniques (the first using a split thickness skin graft to line the organ and the second using a peniscrotal flap) which evolved in Sweden between 1965 and 1995 and conducted on 175 clients at Karolinska Hospital. For Eldh et al. (1997) the introduction of the peniscrotal flap resulted in less complications and greater functionality. The creation of the neovagina had come a long way from that first rudimentary MTF reassignment in 1931 as previously described, to also include the construction of a neoclitoris (Eldh et al., 1997).

Alternative successful techniques are also available including rectosigmoid vaginoplasty (Djordjevic, Stanojevic, & Bizic, 2011). Djordjevic et al. (2011, p. 3488) described the outcomes of 86 cases of this procedure undertaken in Serbia, an internationally recognised centre for SRS. Of those

[10] Les Girls, an all-male-review show began in Sydney in 1963.
[11] April Ashley obtained her surgery in Morocco in 1960 and successfully worked as a model following her return to England (BBC News Liverpool, 2012, December 13).

86 cases, 27 were described as “male-to-female transgender patients,” who underwent reconstructive surgery following the failure of the penile inversion method. The authors reported that 77.77% (21/27) of the trans* patients were satisfied sexually following the operation. This figure is comparable to the overall number of patients treated where 80.23% (69/86) of the cases experienced adequate sexual function.

Some sixty years after Jorgensen’s ‘outing’, SRS is still recognised as an effective medical treatment for the majority of individuals diagnosed with the condition currently known as GD and who undergo the procedure (WPATH, 2011a). Other treatments available to the gender questioning individual may include psychotherapy, hormone therapy and changes in gender expression.[12] Interestingly enough, from the middle of the 20th century, more case reports of transsexual individuals were published and these individuals were labelled as social psychopaths (Cauldwell, 1949), which changed the way the medical establishment viewed this phenomenon, and this particular aspect is explored below.

1.1.2 The psychopathologisation of transsexualism: an introductory exploration

When Dr David Cauldwell (1897-1959), a pioneering sexologist and neuropsychiatrist wrote of his cases in his landmark document *Psychopathia Transsexualis* (1949), he altered the lens through which transsexualism would be viewed in the latter half of the 20th century. In the words of Cauldwell (1949, p. 280), transsexualism was a mental ‘deficiency’ occurring in varying degrees and manifesting itself in “…such practices as seduction,

[12] Gender expression is the personal manifestation of masculinity and femininity and is seen as an extension of our gender identity.

parasitism, violation of the social codes in numerous ways, frequently kleptomania and actual thievery, pathological lying, and other criminal and unsocial tendencies."

This type of thinking laid the foundations for the psychopathologisation of the transsexual phenomenon and the stigma of having a mental disease which proponents of this view argued could be 'cured' through rehabilitation and social education (Cauldwell, 1949; Money, 1994). It was Cauldwell's (1949, pp. 275-277) view that this anti-social behaviour, which could also be accompanied by narcissism, was the result of poor parenting and questionable hereditary. When Jorgensen's operation came into the public spotlight, its eventual effect would be to treat this 'mental disease' routinely with a surgical solution. These developments provided the medical profession with the power to define the transsexual experience as a 'disease' process which could then be controlled under the biomedical model, the dominant discourse in Western medicine (Willis & Elmer, 2011). This biomedical dominance and the psychopathologisation of trans* identities will be discussed in greater detail in the contextual literature review of this thesis.

The classification of Transsexualism as a mental disease was officially sanctioned in 1980 with its inclusion in the DSM-III (American Psychiatric Association). The following section traces the history of its inclusion into the DSM-III (American Psychiatric Association, 1980) and the evolution to the current nomenclature of GD in the recently released DSM-5 (American Psychiatric Association, 2013).

1.1.3 A pathologising journey: from transsexualism to gender dysphoria in the DSM

Although Jorgensen's transformation raised awareness of trans* identities and offered a medical solution to this emerging phenomenon, some criticism existed then (Drescher, 2010) and continued throughout the 60s, 70s and 80s in psychiatric circles as to` the effectiveness of SRS as a treatment. According to Drescher (2010), psychiatric medical culture during that era considered trans* people seeking surgery as delusional. Indeed, as stated by Socarides[13] (1969, p. 1419), "such surgical intervention constitutes a sanctioning of the transsexual's pathological view of reality." Furthermore, Socarides (1969) held the view that transsexualism did not exist.

This archaic notion is based on the definition of a delusion as being a firmly held false belief (Barling, 2005). Such thinking continues to a limited extent (Hakeem, 2008). Hakeem (2008, p. 193) argues that the trans* condition is merely a "symptom rather than a disorder," and that many trans* people play a game of "fraud and deception," likening the trans* person to the narcissistic behaviour of the emperor in the Hans Christian Andersen's *"The Emperor's New Clothes*." In this regard, Hakeem (2008) is mirroring Cauldwell's (1949) notion of the psychopathic transsexual. Additionally, Hakeem (2008) argues that the trans* condition occupies a unique place in psychiatry in that it is the only 'psychological condition' treated with a surgical outcome. Currently, there exists the isolated view that "'sex change' is biologically impossible," and that "people who undergo sex-reassignment surgery do not change from men to women or vice versa. Rather, they

[13] At the time, Dr Socarides was with the department of psychiatry at Albert Einstein College of Medicine, New York, USA.

become feminized men or masculinized women." (Dr. Paul R. McHugh as cited in CNSNEWS, 2015, June 2).

It was and is this 'blinkered' view of the trans* phenomenon that, similarly to homosexuality, led the psychiatric profession to argue that these 'delusional' thinkers could be cured through psychotherapy and psychoanalytic techniques (Drescher, 2010). The point is that it was the predominance of such views which led to the definition of transsexualism as a mental disorder and therefore its introduction into the DSM-III (American Psychiatric Association, 1980). The reason was that it reinforced the innate power of the medical profession in determining the identities of trans* people.

In 1980, The DSM-III (American Psychiatric Association, pp. 261-266) categorised three distinct "psychosexual disorders" related to gender identity,[14] Transsexualism (302.5x),[15] Gender Identity Disorder of Childhood (302.60)[16] and Atypical Gender Identity Disorder (302.85). It was assumed that these classes of disorders were primarily psychological in aetiology. According to the APA (1980, p. 262), the DSM-III also assumed that transsexuals generally had major personality disturbances such as depression (which may lead to suicidal ideation) and anxiety, and were socially and occupationally impaired in the majority of cases. The DSM-III, reflecting theories of sex and gender of the day assumed a binary framework where one was either male or female. Therefore the diagnostic criteria (see Appendix B for a complete list of diagnostic criteria for DSM-III through DSM-

[14] The sense of identifying as a man, woman, both or neither.
[15] 302.5x, 302.60 and 302.85 are classification numbers within the DSM-III.
[16] The diagnosis of children is outside the scope of this study.

5) considered all transsexuals were natal males whose main aim was to "be rid of one's own genitals" (American Psychiatric Association, 1980, p. 263).

In the interim period before the release of the DSM-III-TR in 1987, it became apparent that some symptoms of transsexualism originated in infancy (Winters, 2005). This recognition that the onset of transsexualism occurred in the majority of cases during childhood was based upon the self-reported status of trans* people when they presented for treatment in clinical settings (American Psychiatric Association, 1987). Consequently, in the DSM-III-TR (American Psychiatric Association, 1987), the 'disorders' were reclassified as disorders usually evident in childhood.[17]

Additionally, natal females were included and gender variance was expanded to include trans* people whose aim was not surgery (cross-dressers, drag queens and so on) under the classification of Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT) (302.85). The underlying assumptions of the original version remained in that transsexualism was defined as a mental illness which would become a 'chronic condition' if not treated (American Psychiatric Association, 1987, p. 74).

When the DSM-IV was released in 1994, (American Psychiatric Association, 1994), Transsexualism was renamed Gender Identity Disorder (GID). With this revision of the nomenclature came an increase in the stigmatisation of trans* people due to the inclusion of the word 'disorder'

[17] Although it was recognised in the DSM-III-R that children displayed trans* characteristics, it was not recognised in the SOC until 1998. Up until this time, the SOC were exclusively designed for those trans* people who desired surgery. For a detailed review of the SOC, see page 58 of this thesis.

which accentuated the 'assumed' mental pathology associated with being a trans* person, and highlighted the persistence of the medical and psychiatric professions over the trans* agenda. In the words of Winters (2005, p. 77, emphasis in original), "under the premise of 'disordered' gender identity, transgender women lose any claim to acceptance as *women* but are reduced to mentally ill *'men'.* Transgender *men* are similarly marginalized as confused or disordered '*women'.*"

GIDAANT, which was introduced in the DSM-III-TR (American Psychiatric Association, 1987) was replaced in 1994 with Gender Identity Disorder not Otherwise Specified (GIDNOS) (302.6) and expanded to include other gender nonconforming[18] individuals such as those with intersex conditions[19] and other anomalies in gender identity which broadened the scope of the 'disorder'. Interestingly enough, in contrast to GIDAANT, Criteria C of GID (Appendix B) excludes intersex conditions. In effect, anyone who questioned their gender was now deemed to have a 'mental illness', as Cohen-Kettenis and Pfäfflin (2010) rightly argue. Bower, in his evaluation of the DSM-IV (2001) asserts that these classifications do not require or deserve coding as 'disorders'. The criteria for both these classifications remained unchanged in the DSM-IV-TR (American Psychiatric Association, 2000) from the previous version.

Towards the end of the last decade in the development phase of the DSM-5, it was proposed to rename GID Gender Incongruence (GI), which it

[18] Gender nonconforming refers to an individual's gender identity or expression which differs from socially and culturally accepted norms – not synonymous with gender dysphoria.
[19] Intersex conditions include such conditions as androgen insensitivity syndrome, congenital adrenal hyperplasia, apphalia, clitoromegaly, Klinefelter Syndrome, Swyer Syndrome to name a few and are known as disorders of sexual development.

was hoped would effectively, by the nature of its nomenclature, destigmatise the condition (Vance et al., 2010). Nonetheless, although GI was seen as less pathologising (de Cuypere, Knudson, & Bockting, n.d.), the World Professional Association for Transgender Health (WPATH) recommended to the APA that the diagnosis be known as GD to "…reflect that a diagnosis is only needed for those transgender individuals who at some point in their lives experience clinically significant distress associated with their gender variance" (de Cuypere et al., n.d., p. 6).

Consequently, for the DSM-5 (American Psychiatric Association, 2013) an all-embracing diagnosis of GD (302.6) was formulated to include separate subclasses for children, adolescents and adults. The definition of GD recognised the variations in gender presentation, experience and expression. It included those trans* people who stood apart from the traditional binary framework. Although it recognises these variations, the DSM-5 (American Psychiatric Association, 2013) persists in employing binary language to describe the diagnostic criteria for GD. The main component of the diagnosis now refers to the 'dysphoria' indicating that individuals experience distress and impairment socially, somatically, occupationally or in other areas of functioning.

Therefore, when any trans* person, postoperative, preoperative[20] or non-operative,[21] is comfortable with their gender expression, they effectively have an 'out' from the diagnosis because in those instances, the gender dysphoria no longer exists. This type of thinking goes some way in reducing

[20] Preoperative refers to those trans* people who may or may not undergo SRS.
[21] Non-operative refers to those trans* people who choose not to undergo SRS or those trans* people who are unable to undergo SRS (for financial or medical reasons, for example).

the stigmatisation of the condition and is in line with the view espoused by Y. Smith, van Goozen, Kuiper and Cohen-Kettenis (2005) that SRS recipients are no longer gender dysphoric or that transsexuals suffer from severe disorders (Haraldsen & Dahl, 2000). However, the fact remains that GD is still classified as a psychiatric disorder. My argument is that it still contributes to a sense of internalised transphobia and stigmatisation for those of us who change our social behaviour to avoid discrimination, just as Couch et al. (2007) stated in their study of 253 self-identified trans* people. Of those 253 participants, 64.4% (163/253) of the participants reported changing their social behaviour to avoid discrimination.

The previous section discussed the history of the GIDs in the DSM from 1980 - 2013 and the changing face of the diagnoses from Transsexualism to GD. In summary, these changes reflect a continuing growth in knowledge of the trans* phenomenon and the burgeoning acceptance that the majority of trans* people are not delusional psychopaths, despite the efforts of some modern day mental health professionals such as Hakeem (2008) to maintain the status quo. Given the extent to which the biomedical discourse has invested decades in pathologising trans* identities, I now consider the prevalence of gender variance which demonstrates the significance of this phenomenon in Australia and globally.

1.2 GENDER VARIANCE: THE NUMBERS GAME

Gender variance in its many forms has been documented in most societies around the world for thousands of years with varying degrees of social, political and legal acceptance (Witten et al., 2004). For example, one

of the oldest examples of gender variance can be traced back some 4000 years to India, where the Hijra (neither man nor woman, but a third sex) are still a recognised part of the sociocultural structure of that country and have had their 'third sex' status legally recognised in a landmark decision by the Indian Supreme Court (The Australian, 2014, April 17). The origin of the Hijra is based in Hindu mythology where their "gender ambiguous form" is celebrated through song and dance at festivals and special occasions (Gayatri, 2010, p. 91).

Other examples such as this exist throughout history including the "*mak nyahs"* of Malaysia (Teh, 2001) and the *"fa'afafines"* of Samoa (Vasey & Bartlett, 2007). Nowadays, it is considered that the global population of gender variant people is increasing exponentially due to the variations in gender presentations which exist[22] and trans* peoples' willingness to 'come out' and be recognised. To illustrate this aspect, in the United Kingdom alone, the number of trans* and gender diverse people presenting for some kind of treatment has grown by 11% per annum since 1998 (Gender Identity Research and Education Society, 2011).

In an online study conducted by the UK's Equality and Human Rights Commission (2012, p. 8), it was estimated that 1.4% of the global population has questioned their gender identity to the extent that they have "gone through any part of a gender reassignment process."[23] In the Asia-Pacific

[22] Presentations of gender variance can include, but not be limited to such 'labels' as transgender, transsexual, transvestite, gender fluid, gender queer, cross-dress, drag queen, drag king and so on. The gender continuum is, in itself, a fluid continuum.

[23] The process of gender reassignment includes both thoughts and actions to physically alter from a person's anatomically assigned gender to that of the preferred gender (Equality and Human Rights Commission, 2012).

region, a 2012 report commissioned by the United Nations Development Program speculated that there are 9-9.5 million trans* and gender diverse people in the region (Winter, 2012). Their report also suggests that these figures are underestimated as they relate specifically to trans* women.

From an Australian perspective, the most recent figures on the prevalence of GD were formulated in a study (Ross, Wålinder, Lundström, & Thuwe, 1981), which reported an incidence of transsexualism in Australia of 1:42000 per head of population. In today's terms, this figure equates to approximately 550 trans* and gender diverse people in total in Australia. However, these figures are considered to be substantially underestimated (Veale, 2008) due to increased trends over time and the low response rate to that survey. Only 263 (29.1%) of the 904 surveys distributed were returned. Additionally, statistics gathered from the Gender Dysphoria Clinic of Monash University between 1976-1992 (Bower, 2001) reported a total of 777 applicants (both Male to Female [MTF] and Female to Male [FTM]) for SRS over that period; a considerable number for one clinic. Of those 777 applicants, 202 underwent surgery over that time.

If the estimates provided by the Equality and Human Rights Commission (2012) are more indicative of the actual numbers, the trans* and gender diverse population in Australia could also be considered to have grown rapidly since that 1981 (Ross et al.) survey. With the Australian population approaching 24,000,000 people (Australian Bureau of Statistics, 2012), this equates to approximately 336,000 Australian people who identify as gender variant or gender nonconforming. These figures indicate the probable medical, legal, political, cultural and social significance of GD within

the Australian community for a pathologising and stigmatising condition where no definitive aetiology has been determined. However, current medical opinion considers that its origins are both congenital and environmental (Hare et al., 2009; L. Jones et al., 2008). These aetiological considerations are discussed in the following section.

1.3 THE AETIOLOGICAL MELTING POT: ARE WE ANY CLOSER TO THE CAUSE?

History informs us that the aetiological basis of the trans* condition is steeped in conjecture and multiple theories (Cohen-Kettenis & Gooren, 1999). According to Cohen-Kettenis and Gooren (1999) and Benjamin (1966), much of this conjecture included such notions as the psychopathology of parents and their influence, wanting a baby of the opposite sex and separation from a father figure. Conjecture also suggested a more sinister causation by being linked to the work of the devil (Childs, 2009). Biological and endocrinological factors, although noted as possible early in the 20th century (Benjamin, 1966; Cohen-Kettenis & Gooren, 1999) faded into the background as the psychopathologisation and medicalisation of the trans* condition expanded from the middle of the 20th century as previously discussed.

Biological factors have been vigorously researched and debated (Chung, de Vries, & Swaab, 2002; Dohler et al., 1982; Hare et al., 2009; Kruijver et al., 2000; Lawrence, 2007; Zhou, Hofman, Gooren, & Swaab, 1995) in the last 30 years as a possible aetiology. Recently, in a 2009 joint American/Australian case control study (Hare et al., 2009) involving 112 MTF

transsexuals and 258 non-transsexual controls, the authors found a significant association ($p = .04$) between the repeat lengths of the androgen receptor (AR) allele and MTF transsexualism. In the majority of cases, the length of the AR allele was longer than the non-transsexual controls. Although other biomarkers such as the Estrogen Receptor ($ER\beta$) and the aromatase (CYP19) genes were not indicated, this study added weight to arguments that the condition could be biological in nature.

The size of the sample was the major strength of this study, being the largest genetic study of MTF transsexuals conducted to date. Hare et al. (2009) acknowledged the major limitation of this study was that its sample included only MTF transsexuals and could be expanded to use other populations. When Hare et al. (2009) compared their results to an earlier Swedish study, the authors implied that there could be differences in the results based upon ethnicity and geographical location. I would argue that this notion is a feasible assumption to make for the reason that ethnic and cultural groups evolve in relation to their environmental circumstances.

However, it is rightly argued that this evidence in itself is inconclusive and some would suggest sketchy at best (Lane, 2011; Lawrence, 2007). In a study (Lane, 2011) that examined the social and political implications of a biological aetiology from a feminist perspective, the author argues that trans* specific studies to date which have explored associations with genes, hormones and neuroanatomy have contradictory results and weakly generated samples based upon various definitions of the trans* experience. Lane (2011) proposes that the aetiological argument should diverge from the 'nature versus nurture' debate which consumed the 20th century, with trans*

activists, clinicians, sociologists, psychologists, neuropsychiatrists and so on each approaching the debate from all points on the spectrum.

Lane (2011) argues that the extremes of the spectrum (transsexualism as a healthy biological variation or severe psychological disorder) do little more than concretise the dichotomy of the debate and disrespect the diversity of the trans* experience. There continues to be a lack of solid scientific evidence and opinions do vary across the entire spectrum. To illustrate the various opinions expressed on trans* aetiology, Lane (2011) developed a three dimensional representation of the participants' views in that study (n = 26) and other figures based upon their knowledge base and discipline (n = 4).[24]

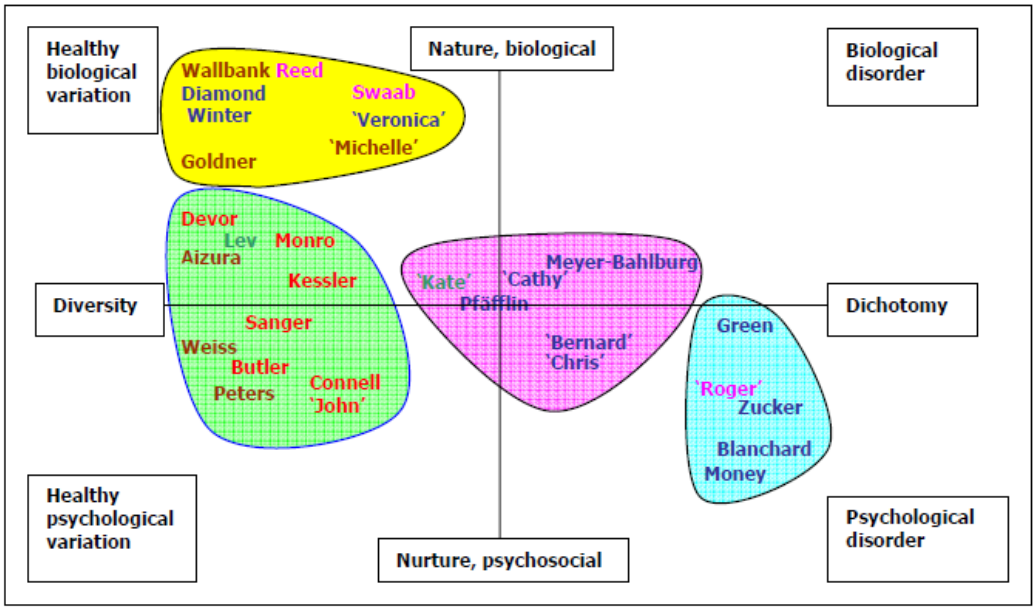

Figure 1. A three dimensional representation on the aetiology of the trans* experience (Lane, 2011, p. 190).[25]

[24] The people represented in this figure come from a wide variety of disciplines including psychological and psychiatric clinicians in purple font, other clinicians in green font, trans-activists in red font, and biological researchers in pink font.
[25] Permission to use this figure is located at Appendix C.

The views are situated along three broad positions as illustrated in Figure 1; diversity versus dichotomy, health versus pathology and nature versus nurture. Additionally, the views are clustered to signify the general positions of those people; healthy biological variation highlighted in yellow, transgender activism-social research highlighted in green, middle ground clinicians highlighted in pink and psychological disorder highlighted in blue. The final point is that the diversity of responses, views, positioning and the lack of solid scientific evidence indicates that trans* aetiology is still subject to conjecture and multiple theories and may never be reduced to one single factor for the reason that the respondents continue to espouse their views at the expense of alternative theories and the recognition that gender expression is complex and takes multiple forms.

The complexity of the trans* phenomenon and in particular GD and SRS has thus far been examined from several perspectives. I introduced the surgical history in the modern era and took the opportunity to provide examples of successful trans* women who made that journey to self-fulfilment. The success of those women came at a cost to the wider trans* community by ensuring that the dominant discourse, the biomedical model, assumed the power of their rites of passage through the inclusion of Transsexualism into the DSM-III in 1980. The psychopathologisation of Transsexualism has itself taken many turns in its own journey through to its latest inclusion in the DSM-5 as GD in 2013; a somewhat tamer version of that supposed mental disorder, albeit still classified as a diagnosable mental illness.

I then turned my focus to the prevalence of gender variance globally and from an Australian perspective. Historically, gender variance has existed for thousands of years in various cultures around the world. This examination highlighted the exponential growth of gender variant people worldwide as it is not as simple to say that gender is a binary notion. Gender presentation is an individual choice which is a fluid, dynamic process for some and a static, binary process for others. Additionally, it highlighted the significance of the trans* phenomenon through estimating >300,000 gender variant Australians. Finally I discussed the various theories surrounding the aetiology which have been espoused over the last century. Those theories are biological, environmental, endocrinological and psychological in nature and it is clear from the discussion that no solid evidence exists to claim one singular cause. One factor, however, that is evident is the significance of the trans* phenomenon and the need to further our understanding of that phenomenon. I now turn the discussion to the current project and its context as a qualitative research project and I reflect on my position as the researcher in that project.

1.4 RESEARCH IN CONTEXT

1.4.1 Situating the research

SRS is an irreversible surgical treatment undergone by some individuals diagnosed with GD. With improved surgical techniques, the increase in the number of trans* people globally and the widespread availability for both trans* men and trans* women, its popularity as a course of action has increased. It is well documented that the quality of life of the

majority of SRS recipients improves following surgery and that there is an increase in health and wellbeing over the longer term (Collyer & Heal, 2002; de Cuypere et al., 2005; Lawrence, 2003; Parola et al., 2010).

However, the current study was not interested in long term outcomes of the surgical process. The current study was designed and conducted in order to gain a better understanding of the thoughts, feelings and experiences of trans* and gender diverse people who have undergone SRS and the processes involved in navigating this life changing event. Broadly speaking, the project sought to understand the participants' perceptions of their needs as they progress through that surgical transition and how systems can be improved to cater for those needs.

Trans* people have long suffered stigma, social discrimination and social isolation. Their bodies and minds have been described as being controlled by a "mono delusional belief" (Hakeem, 2008, p. 184). Having the opportunity to reconstruct their perceptions of an event (the surgical process) through artistic, textual and verbal 'ways of doing' gave the 14 participants an affirmation of their social legitimacy. This legitimacy was achieved through the interactions with me as the researcher who became embedded in the research process. Research of this type is not a static construct. It relies on the interplay between the participants, the researcher, the literature, social processes and legal frameworks; all of which must be considered as components of the material.

This study is unique in that it is the first qualitative study conducted in Australia to include both trans* men and trans* women who have undergone SRS concerning SRS. It makes an important contribution to the knowledge

base on this phenomenon for the reason that it clearly demonstrates that social and legal structures impede trans* identities in this country from achieving social and legal parity with their cisgender[26] counterparts. I turn now to an explanation of my motivation in conducting this research which includes a reflexive discussion situating my positionality in the research.

1.4.2 Situating my positionality

From a personal perspective, my interest in the psychosocial dimensions of the transition process stems from my own recollections of my transition. I began my formal transition in 1974, starting with hormone therapy, which in those days was largely available on the 'black market', although some GPs were willing to prescribe drugs such as diethylstilboestrol.[27] Diethylstilboestrol was the drug of choice by a substantial number of trans* women of that era because of its rapid physical effects and its ease of availability. In December 1977, I underwent a mammoplasty, which went some way to reduce my dysphoria. In some ways, this change to my physicality created an even more unruly body with a mismatch between top and bottom. I had been living as a female for almost seven years when in 1981 I decided to go through the final part of the physical transition process – SRS. So, for the next fourteen months, I was assessed by psychiatrists, psychologists and a gynaecologist on my suitability for surgery.

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[26] A cisgender person in its simplest construct refers to any individual that is comfortable with their assigned gender. That is to say, not a transgender person. It also describes a form of social privilege.
[27] Diethylstilboestrol, or DES (also known as stilboestrol), is a synthetic oestrogen which was used between 1940 and the early 1970s to prevent miscarriage in women with a previous poor pregnancy outcome and has been linked to vaginal and cervical cancer (Therapeutic Goods Administration, 2008).

I recall being given the ‘go-ahead’ for the surgery in late 1982 while I was busy working (as a female stripper and dancer) and studying (to be a computer programmer) in Melbourne, Victoria. The surgery was scheduled for February 25th 1983. From the time of that approval, involvement with medical professionals was limited to those specifically concerned with the surgical procedure (the gynaecologist and the plastic surgeon) to discuss surgical technique and expected outcomes (including risks). The only other professional contact was with lawyers to sign papers designed to protect the multidisciplinary team from legal action in the event of a failed operation (if one did not sign these papers, the operation would be cancelled).

Receiving the approval for surgery meant there was no further requirement to see psychiatrists and/or psychologists again and at the time this was an affirmation that I (and many like me) were ‘normal’ and could happily make that physical transformation from our natal sex to our preferred gender. However, in retrospect, although SRS is seen to be “effective and medically necessary” for some individuals (WPATH, 2011a, p. 54), the final transition represents a change that is indeed ‘final’. The point is that SRS is an irreversible procedure. Although the irreversibility of the procedure is and was common knowledge, I was unsure that we (health professionals and clients) fully appreciated how to negotiate that process for the reason that there was no further contact at a therapeutic level.

This particular aspect was highlighted following my surgery when, during the early postoperative period, I recall having an emotional outburst, the reasons for which were not evident. Perhaps it may have been a reaction to the physical loss, relief that the procedure was over, momentary regret, the

level of extreme pain associated with a lengthy and traumatic operation or even being in a highly drugged state. The nurse questioned my emotional state by commenting that I got what I wanted, so I should be happy (much like Dee Dee's conversation with the plastic surgeon). This response disregarded those very social and psychological supports required to make a smooth transition at this life changing moment in time.

This program of research was inspired by certain findings of a previous project I conducted in fulfilment of my Honours program at QUT (Chaplin, 2011). That project had critical first time significance in that it steered away from a quantitative approach to deal with psychosocial issues surrounding SRS. The purpose of that study was to explore the life experiences of Australian trans* people who had undergone SRS and explore what influences the surgery had on their daily lives and social functioning. In that study, the narratives of three postoperative trans* women conveyed a sense of loss which I interpreted as being a direct result of the surgical process. My previous research suggested that following SRS people have complex psychosocial issues, not the least of which are feelings of grief and loss associated with the procedure and the development of personal identities. In that study, one participant in particular likened the irreversible surgery to an amputation. I suggested that these losses were socially constructed, specific to the individual and affected the relationships between trans* people and their social networks. In addition, working through those losses (grieving) relied upon the strength of those personal relationships and the mental resilience of the individuals. These findings align with clinical work in the field (Emerson & Rosenfeld, 1996; Zamboni, 2006).

One interpretation of the material in this earlier project was that little concern is given to the loss and grief that was associated with the surgery and it was argued that these feelings were directly related to the surgical amputation of the genital organs for all three of my participants. The positive outcomes of the surgery that trans* people conceptualise, such as hope for the future, improved social functioning and positive self-image can be inconsistent with the actual feelings of loss that an amputation brings.[28] It is possible that these difficult emotional processes are not considered (by medicos and clients alike) prior to the surgery because the anticipation of future benefits obscures them. Despite the anticipation of a positive outcome and the alignment of the corporeal self with the psychological self, SRS still involves the loss of body parts.

Additionally, the current SOC [Version 7] (WPATH, 2011a) for psychotherapy concerning SRS appear vague and open to individual clinician interpretation at every stage of the process. It should be noted that WPATH (2011a) does not consider psychotherapy as pathologising. WPATH (2011a, p. 10) views psychotherapy as a process intended to enhance an individual's wellbeing through exploring avenues to minimise gender dysphoria including "exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience."

[28] I propose that this phenomenon would equally apply to both MTF and FTM trans* people despite that particular project's limitations in only involving three MTF trans* women.

Moreover, psychotherapy is not considered to be a mandatory part of the hormonal/surgical transition process (WPATH, 2011a, p. 28). Of particular concern are psychosocial needs once the client is assessed as suitable for surgical transformation. On reflection, it was this interpretation from the previous project that the losses associated with the surgical process were possibly overlooked and the seemingly ad hoc approach to psychotherapy that influenced my decision to look more deeply into the psychosocial dimensions of the experience of SRS, hence the focus of the current research. It is clear from the preceding discussion that the background to the current study, including my personal narrative, which contextualised the factors that inspired me to undertake this project, is significant in itself and are linked directly to the aims and objectives of the current study, which follow.

1.5 AIMS AND OBJECTIVES

Little is known on the psychosocial needs of trans* people undergoing SRS. Therefore, the purpose of this research was to understand the meanings that the participants constructed in relation to their psychosocial experiences during the final surgical transition from their biologically assigned gender to their preferred gender.

This research had four main aims. The study aimed to:

- Contribute to the body of knowledge of the trans* phenomenon

- Understand the psychosocial aspects of the lived experience of trans* and gender diverse people undergoing SRS and if they perceived their needs were met
- Explore the implications of these findings in relation to the existing guidelines (SOC), and finally to
- Explore the implications of these findings in relation to the Australian legislative framework

The research question that has been framed from these aims and objectives is: “How do trans* and gender diverse people who have undergone sex reassignment surgery (SRS) perceive their psychosocial experiences of the surgical transformation?” As this study specifically relates to those trans* men and women who have undergone SRS, it is necessary to define SRS along gendered lines in the Australian context, as these definitions dictated the recruitment of participants for this study.

1.6 SEX REASSIGNMENT SURGERY: TWO OR MORE BODIES

WPATH (2011a, p. 95) defines SRS as “surgery to change the primary and/or secondary sex characteristics to affirm a person’s gender identity.” In itself, this definition appears quite appropriate as a generic definition. Nonetheless, when one considers those sexual characteristics as they related to male and female and the manner in which the Australian healthcare system operated in respect to those sexual characteristics, defining this term becomes more complex. WPATH (2011a, p. 3) recognises

the limitations of the SOC in relation to local social, legal and cultural practices around the world and the impossible situation of catering for all those nuances in the SOC.

Up until recently, the Australian healthcare system exclusively relied on a binary framework of male and female. Following the introduction of Commonwealth guidelines in July 2013 to be sex and gender inclusive, this situation has changed somewhat (Australian Government, 2013). Prior to the introduction of these guidelines, the relationship between this binary framework and trans* identities became difficult to manage when trans* people were the recipients of care. For example, some medical and surgical procedures such as mastectomies, hysterectomies and prostate related procedures (all of which can be implicated in SRS), to name a few were deemed to be gender specific and the person undergoing these particular procedures did not legally fit that framework due to changes in legal sex and gender on personal documentation.

Drawing upon Deutsch et al. (2013, p. 1), systems do not adequately cater for "a man with a cervix or a woman with a prostate." The introduction of these guidelines, which presently only apply at the Commonwealth Government level, aimed to develop a consistent classification system on Commonwealth Government records and a consistent standard of evidence to change sex and gender markers (Australian Government, 2013). The main problems with these guidelines is their somewhat insular focus; they are not applicable at the State and Territory levels of government and the point that these guidelines are just that – guidelines, and could be revoked by any incoming Commonwealth Government should they decide to do so. Despite

this recognition and the neutrality of gender markers, The Royal College of Australasian Physicians (2015, p. 1) note that “Medicare item numbers do not exist for therapeutic surgical procedures which prevents surgical care being provided in public hospitals or being subsidised in private settings.”

1.6.1 Trans* woman or male to female (MTF)

Surgery for trans* women is relatively simple in that it generally involves only one major operation (excluding complications). The procedure has been successfully performed in Australia in the public and private health systems since the mid-1970s (Bower, 2001; Damodaran & Kennedy, 2000). It includes procedures such as vaginoplasty, penectomy, orchidectomy, clitoroplasty and vulvoplasty (WPATH, 2011a, p. 57). It is well known amongst Australian trans* networks that, prior to the provision of services in Australia in the 1970s, Australian clients went overseas to places such as Hong Kong and Egypt to access appropriate surgical treatment.

Indeed, even today, although Australia still offers the services to perform these surgical procedures, many trans* women decide to go overseas to such places as Thailand (Stolley & Watson, 2012) to seek surgical transformation because the surgery is no longer publicly subsidised in Australia. Additionally, the actual cost of surgery is also substantially cheaper in places such as Thailand compared to Australia. Prior to the introduction of Medicare under the Hawke Labour Government in 1984, SRS was available publicly and free of cost. Soon after the introduction of that legislation, the status of SRS was altered to reflect its assumed classification as elective, cosmetic surgery. Anecdotal evidence suggests that the surgery is reconstructive in its nature. However, as WPATH (2011a) suggest, the

reconstructive/cosmetic debate has no clear distinctions. In their view, the answer may reside in the amount of relief from GD the procedure provides to the recipient of care.

This change in arrangements meant Medicare rebates were no longer available. Additionally, the cost of such surgeries was not claimable through private health insurance for those very same reasons. One trans* advocate (K. Noble, personal communication, March 6, 2014), believes this situation continues to be a source of frustration amongst the trans* community and has a detrimental effect on the mental health status of those individuals whose aim is surgical transformation and do not have the financial means to satisfy that need.

1.6.2 Trans* man or female to male (FTM)

SRS for trans* men is complex and multi-faceted in nature and includes multiple surgeries which are anecdotally and medically known as 'top' and 'bottom' surgeries (Newfield, Hart, Dibble, & Kohler, 2006). According to WPATH (2011a, p. 57), surgeries for trans* men include subcutaneous mastectomy and creation of a male chest for the 'top', and, hysterectomy, oophorectomy, vaginectomy, scrotoplasty, metoidioplasty and phalloplasty for the 'bottom'. 'Bottom' surgery for trans* men has never acquired the same level of success as it has for trans* women due to the intricate nature of surgically constructing a penis, the greater risk of complications, and the variability of surgical techniques (WPATH, 2011a, pp. 63-64).

Phalloplasty and metoidioplasty are not currently performed in Australia. Through my association with the trans* and gender diverse community and as a member of the Australian and New Zealand Professional Association for

Transgender Health (ANZPATH), I know of one Australian gender reassignment surgeon who was receiving training overseas to perform bottom surgery, but has not practised to date. Therefore, those trans* men who do decide to pursue phalloplasty and metoidioplasty as a necessary outcome to relieve their gender dysphoria need to do so overseas, which in itself is a source of frustration for those approved for the operation. Through conversations with trans* men, many decide to go no further than a hysterectomy and/or oophorectomy being mindful of the risks that further 'bottom' surgery brings, the lack of guarantees of success and the added burden of going overseas to be treated due to the complexity of the multiple surgeries. Finally, many FTM clients only undertake 'top' surgery. (WPATH, 2011a, p. 63).

1.6.3 Defining SRS for this study

SRS is defined as surgery which includes any or all of the following procedures as set out in Table 1. These procedures are recognised as constituting SRS by WPATH (2011a). Obtaining a diverse participant base was a paramount consideration from the outset of this project, and this initiated the need to formulate a definition of SRS which would be inclusive of the greatest number of trans* men and trans* women.

Table 1

Surgeries Classified as SRS

Gender	Types of Procedures	
Female to Male (FTM) or Trans* Man	Mastectomy	male chest creation
	Hysterectomy	removal of uterus
	Oophorectomy	removal of ovaries
	Vaginectomy	removal of vagina
	Scrotoplasty	scrotal construction
	Metoidioplasty	clitoral extension
	Phalloplasty	penile construction
Male to Female (MTF) or Trans* Woman	Vaginoplasty	vaginal construction
	Orchidectomy	removal of testicles
	Penectomy	removal of penis
	Clitoroplasty	clitoral construction
	Vulvoplasty	labial construction

Note. Adapted from "Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People 7th Version," by The World Professional Association for Transgender Health (2011a, p. 57).

1.7 A PREVIEW OF WHAT LIES AHEAD

Chapter 2 examines the clinical literature that exists in relation to the primary care needs of trans* people during the transition process, and more specifically, during the final physical transformation through SRS. The review also includes literature that reports on research into the psychosocial aspects associated with the transition experience including loss and grief and personal identity development. It critiques the medicalisation of the trans* phenomenon and the effect the biomedical system of healthcare delivery in relation to the trans* experience. Furthermore, it situates the Australian trans* experience from a medical perspective and discusses the evolution of the SOC from its inception in 1979 [Version 1] to 2011 [Version 7]. Finally,

this chapter highlights gaps in the literature which demonstrates the importance and significance of this research.

Chapter 3 argues and justifies the theoretical framework and the methodology which was developed for this study. The 'ways of knowing' were adapted from the theories of embodiment, narrative and social constructionism. Several key theoretical concepts from the works of Berger and Luckmann, Ricoeur and Merleau-Ponty are examined as they provided the view through my theoretical lens. Importantly, it aims to show the relevance of those theories to this study on trans* people and how those theories informed the methods employed in this study.

Chapter 4 details, discusses and explains the 'ways of doing.' Firstly, sampling, participant selection and recruitment are discussed. Demographic details of the participants are provided. The reasoning behind selecting two methods of data generation (participant-produced drawings and interviews) is argued and justified. The approach taken to data analysis is described. Finally, ethical considerations and dilemmas for this study are discussed followed by a discussion of rigour, including the researcher's position as sharing the space between insider and outsider in this research.

Chapters 5 and 6 details the results and presents the 'ways of interpreting' those results with reference to the literature and existing theories. The discussion is organised in relation to four narrative concepts developed upon the perceptions of the participants. These chapters explore the following dimensions: *navigating the personal self, navigating the social self, navigating the medical self* and *navigating the legal self.*

Chapter 7 is the final chapter and concludes this thesis. It presents a synopsis of the key findings of this study and interrogates those findings against the literature, the theories, the methodology and the ways in which the research process unfolded. It endeavours to make sense of the complexities of everyday life as a trans* person in the 21st century and offers possible solutions to unravelling those complexities. Given the paucity of information on the local contextual needs of being trans*, possible areas of further research are highlighted. I conclude with a personal reflection, an essential component of narrative research, and link this back to the body of the thesis in relation to my positionality in this research.

Chapter 2: The literature: a contextual review

> All knowledge in this area is provisional and speculative, due to the inadequate research base, the disciplinary biases on all sides, and the extreme personal emotional sensitivity of discussion of trans people's identity. (Lane, 2008)

2.1 INTRODUCTION

The work that follows in this chapter critically examines the literature that exists in relation to the needs of trans* people during the transition process, and more specifically, during the transformation through SRS. The majority of the literature is based upon quantitative studies and reports by clinicians in the field. Quantitative studies, although very useful in quantifying the numerical attributes of phenomena do not provide an in-depth understanding of those phenomena. The knowledge base of the trans* phenomenon in Australia is quite limited for the reason that there is a paucity of studies on the phenomenon of SRS. This project provides new perspectives on transitioning in the Australian context by examining the experiences of trans* people who have undergone SRS.

The literature examined is not exhaustive of the literature that exists in relation to SRS. The field of transgender medicine has evolved over several decades as indicated in the previous chapter, and in the main, was concerned with surgical procedures. Those particular concerns are beyond the focus of this review and will not be dealt with in great detail. Similarly, literature dealing with the care of children and adolescents will not be

reviewed as SRS is not necessarily a component of their care trajectory. It does, nonetheless, provide a synthesis of relevant works along the following broad themes: the primary care needs of trans* people and reshaping identities. The literature relating to primary care needs suggests the relative preoccupation with the physical care of trans* people while the literature on reshaping identities reports on research which examines the psychosocial aspects associated with the transition including identity development, the complex issue of loss and grief and the medical and social manipulation of trans* identities. Finally, and equally important, this review discusses in detail the evolution of the SOC for trans* and gender diverse people for the reason that it is these guidelines that impact upon medical and psychological care.

2.2 PRIMARY CARE NEEDS OF TRANS* PEOPLE

It is necessary at the outset to state that the majority of the literature reviewed in this section is in part the work of clinicians in the field (both medical and nursing). It describes their current practice and therefore is not reporting on research in the field as such. In the last decade, the primary care needs of transsexuals have been addressed by several medical practitioners and experts in the field (Bowman & Goldberg, 2006; Feldman & Goldberg, 2006; Jenner, 2010; Sobralske, 2005; Williamson, 2010). This knowledge has followed on from the work over the last five decades in the evolution of transgender medicine, where the main focus was upon the surgical transformation to the desired gender as medically necessary treatment (Collyer & Heal, 2002; de Cuypere et al., 2005) and the continued

improvement in surgical techniques to achieve the desired client results (Eldh et al., 1997).

To illustrate the improvement in surgical techniques, Eldh et al. (1997) conducted a long term follow-up of 136 transsexuals operated on at the Karolinska Hospital in Sweden between 1965 and 1995. The purpose of the study was to evaluate surgical outcomes (cosmetic and functional) of SRS. The authors described the continued improvement in surgical outcomes over that period and these improved surgical outcomes resulted in greater patient satisfaction and quality of life for the vast majority of patients. Several studies found similar outcomes in reference to long term patient satisfaction and quality of life issues (Chaplin, 2011; Collyer & Heal, 2002; Duisin, Rakic, Nikolic-Balkoski, & Cavic, 2002; Lawrence, 2003; Parola et al., 2010; Udeze, Abdelmawla, Khoosal, & Terry, 2008).

In consideration of the primary care needs of transsexuals, Bowman and Goldberg[29] (2006) provided guidelines on the care of both male to female (MTF) and female to male (FTM) clients with the aim of orientating general physicians on the specialised process of gender reassignment. The authors discussed the various feminising and masculinising surgical procedures available, for example, breast augmentation and genital reconstruction[30] in the case of MTF transsexuals and for FTM clients,[31] subcutaneous mastectomy, breast reduction, hysterectomy and

[29] At the time of publication, Dr Cameron Bowman was affiliated with the Division of Plastic Surgery, University of British Columbia, Vancouver, BC, Canada. Joshua Goldberg was Education Consultant of the Transgender health Program, Vancouver, BC, Canada.
[30] There are many types of genital reconstructions performed including vaginoplasty, orchidectomy without vaginoplasty, penectomy without vaginoplasty; all of which are classified as valid surgical options open to the MTF client. The choice will depend on the expectations of the client and the physical assessment.
[31] All surgical procedures for FTM clients are considered as SRS.

oophorectomy, vaginectomy and phalloplasty. Bowman and Goldberg (2006) also considered the possible negative physical and psychological outcomes and risks, including regret and surgical complications such as vaginal stenosis and recto-vaginal fistulae, associated with the abovementioned surgeries. However, from a psychosocial perspective in the preoperative stages, Bowman and Goldberg (2006) provide only a generic description by stating that clients should be prepared psychologically for the surgery.

On the other hand, Jenner (2010), a nurse practitioner, examined the care needs of transsexuals from a cultural and clinical viewpoint and how these factors affect the healthcare of the transsexual population. As reported by Jenner (2010), transsexuals face particular complexities as a result of their gender both psychologically (issues of social discrimination and exclusion and the decision to permanently alter lifestyles), and physiologically (hormone therapy and surgical options). In reference to preoperative psychological care, Jenner (2010) advocates counselling over an extended period to confirm the diagnosis and to ensure that the irreversible procedure of SRS is based upon appropriate counselling, hormonal therapy and competent lived experience. These recommendations are based upon the SOC [Version 6] of WPATH (Meyer et al., 2001). Jenner (2010, p. 406) concludes by generalising that postoperatively, transsexuals need "considerable adjustment" and that counselling should continue based upon judgements made by the care provider. However, Jenner (2010) neglects to explicate what these adjustments may be.

In another article, Feldman[32] and Goldberg (2006) noted the dearth of information related to transgender medicine. The authors' main aim was to discuss a range of medical care issues (diabetes mellitus, substance abuse, cancers, cardiovascular disease, HIV-AIDS, sexual, musculoskeletal and mental health) from an evidence based approach using a holistic model as defined by the World Health Organisation (1978), where consideration is given to the bio psychosocial health of the individual. Feldman and Goldberg (2006) linked transgender issues to the diversity of the population and suggested a flexible approach in treatment guidelines similar to the SOC [Version 6] previously noted (Meyer et al., 2001).

It is not the purpose of this review to examine these medical issues in detail. However, medical issues discussed revolved around hormonal therapy for both MTF and FTM transsexuals and its effects. For Feldman and Goldberg (2006), the risks associated with the use of hormone therapy are controversial in some instances. For example, in relation to bone density following SRS, the level of therapy required to maintain adequate density for both FTM and MTF transsexuals is unclear.

For the trans* client undergoing SRS, Feldman and Goldberg (2006) suggest a general supportive approach with counselling (professional and peer) to facilitate surgical preparation and adjustment as a possible treatment option. However, the authors do not provide any detail on the types of counselling that may be available or warranted. For the postoperative patient, the authors focused on wound healing and possible physical

[32] At the time of publication, Dr Jamie Feldman was affiliated with the Department of Family Medicine and Community Health, University of Minnesota Medical School, Maine, USA.

complications of the surgery which may need revisionary surgery, as well as ongoing screening for other medical issues. Yet, Feldman and Goldberg (2006) made no mention of possible psychosocial issues associated with the surgery such as loss and grief or possible mental health issues such as depression and the like, contradicting their original premise of treating trans* patients from a holistic perspective.

Similarly, Sobralske (2005), a nurse practitioner, examined elements of the transition according to physical attributes of the process for both MTF and FTM transsexuals. In this review of the literature and the expert opinion of surgeons in the field, the main focus of the inquiry was to inform nurse practitioners (NPs) for the purpose of hormone therapy and reassignment surgery, including the effects of these treatments on body systems, and the health problems that may ensue as a result of those treatments as described by Feldman and Goldberg (2006). Unlike Feldman and Goldberg (2006), Sobralske (2005) included ethical guidelines for gender reassignment treatment which were introduced in the SOC [Version 5] (WPATH, 2011b) in order to inform NPs of their responsibilities in this area. However, Sobralske (2005) overlooked any psychosocial interventions that may apply during the transition.

From another clinical context, Williamson (2010) discussed the provision of care options for trans* people from an NP's perspective, but also included sexual health following SRS and HIV management. Williamson (2010) noted that health practitioners should take a mental health history and make arrangements for referral to a mental health practitioner for counselling during the transition. Williamson (2010) also noted the difficulties faced by

some trans* people such as ‘coming out’ and the possible consequences of that process, including loss of family and friends and legal issues. Williamson’s (2010) main focus, however, was concerned with the physical transformation and the possible medical and surgical issues that may follow the transformation such as the susceptibility of postoperative genital tissue to infection and strictures.

In contrast, Bockting, Knudson and Goldberg (2006) discussed the assessment, care and treatment of transgender individuals and their families from a mental health perspective. The authors provide extensive clinical pathways for care options from the initial client evaluation to the written recommendation to prescribe surgery. These pathways included the development of a mental health and gender care plan tailored to the individual’s needs and these pathways concur broadly with the requirements of the SOC [Version 7] (WPATH, 2011a). However, according to Bockting, Knudson and Goldberg (2006), once the recommendation to proceed with surgery has been made, any further resources to assist the final transition are discussed at the client’s request. This approach implies no other psychotherapeutic interventions are required to adequately prepare the client for that final transition to their preferred gender.

The material thus far covered in this review on the primary care needs of trans* people as they prepare for and/or have undergone SRS overwhelmingly demonstrates the preoccupation of the physical and medical aspects over the psychosocial considerations (Bowman & Goldberg, 2006; Feldman & Goldberg, 2006; Sobralske, 2005; Williamson, 2010). There is no denying that the physical and medical aspects of transition are indeed

important with a change in hormonal activity and bodily functions associated with the surgery. Side effects of long term hormone use such as cardiovascular and osteoporotic conditions, for example, are important for ongoing care. Equally important in the development of personal identities are those psychosocial considerations, some of which, it is argued, are complex in nature.

2.3 TRANSITION: RESHAPING IDENTITIES

2.3.1 Personal identity development

Although the physical transformation by SRS is a very important aspect of the primary care needs of the transsexual person, the psychosocial transition is equally important for the successful adaptation to the preferred gender and functionality as the preferred gender (Bockting et al., 2006). According to Bockting et al. (2006), psychosocial adjustment is an ongoing phenomenon throughout the trans* person's life. Furthermore, it is argued that this adjustment is necessarily part of identity development (Morgan & Stevens, 2012). In a semi-structured, descriptive narrative study taken from a postmodern feminist perspective (Morgan & Stevens, 2012), five MTF preoperative trans* people and one MTF cross-dresser were asked to relate their lifespan stories on their trans* experiences. This sample was part of a larger study that interviewed 11 transgender adults including FTM people. Morgan and Stevens (2012, p. 307) theorised that the process of transition was essentially "staged and developmental" as the participants' narratives followed similar life experiences.

These experiences included recognising the difference between the corporeal and psychological self at an early age, learning how to construct this psychological self and negotiating the transition process. This study (Morgan & Stevens, 2012) highlighted the social humiliation, compromise and rejection faced by preoperative trans* people as they negotiate their developing identities. However, the study was limited in that the sample did not include any postoperative trans* people. That study was further limited by not including the findings from the data of trans* men from the larger study, which would have added to the complexities of this identity development and enriched the findings of that project. This further highlights the significance of the current project which included trans* men and women who had undergone SRS from an Australian perspective. This leads me to explore the concept of identity development in the Australian context.

2.3.2 Situating Australian identities

In the Australian context, the literature base is quite narrow. Since 2002, studies have examined several issues in relation to trans* identities in the adult population (Collyer & Heal, 2002; Couch et al., 2007; Hyde et al., 2014; T. Jones, del Pozo de Bolger, Dune, Lykins, & Hawkes, 2015; Riggs & Due, 2013; E. Smith et al., 2014). In a mixed methods study on the health and wellbeing of trans* people in Australia and New Zealand (Couch et al., 2007), several psychosocial issues were identified as part of the development of the trans* identity. This online study surveyed 161 preoperative[33] and 92 postoperative trans* people (48 MTF and 44 FTM)[34] in

[33] The 'preoperative' trans* people in this report include those that self-identify as transsexual, bi-gendered, cross-dresser, androgynous and queer to name a few.

order to identify the "variation of identity and experience" (Couch et al., 2007, p. 6) in this diverse population. For Collyer and Heal (2002, p. 9), the main focus of their study was an "evaluation of the effect of sex re-assignment surgery" in terms of patient satisfaction with SRS. This quantitative study surveyed 57 MTF transsexuals who underwent SRS between 1988 and 2000 who attended a private clinic in New South Wales. In another study, Riggs and Due (2013, p. 7) reported the results of two online surveys. The first survey, undertaken in 2012 included 78 participants who identified as "female assigned at birth and but who now identify with a different gender identity." The second survey, conducted in 2013 included 110 "people who identify as transgender women." Riggs and Due (2013) aimed to explore identity recognition, engagement with the healthcare system and importance of community connectedness on mental health outcomes.

In another online study, Hyde et al. (2014) surveyed 946 trans people (482 trans women, 232 trans men, 136 assigned female at birth who identify as non-binary and 96 assigned male at birth who identify as non-binary). Hyde et al. (2014, p. iv) aimed to investigate "the mental health and well-being of trans people in Australia." A further recent study (E. Smith et al., 2014, p. 23) combined an online survey with "online text based interviewing" with 189 young people aged from 14-25 to explore the mental health needs of this population. Finally, T. Jones et al. (2015, p. xiii) combined an online survey and online discussion board on 273 FtM transgender people

[34] FTM transsexuals include those that have undergone chest construction, mastectomy, hysterectomy, oophorectomy, phalloplasty and metoidioplasty.

(preoperative and postoperative) which aimed to "increase the visibility of FtM transgender Australians and their needs."

Lived experience

According to Couch et al. (2007), the lived experience of both preoperative and postoperative trans* people involves recognition and negotiation of their public and private lives, the transition itself and their relationship with the healthcare system. Couch et al. (2007) identified that considerable variation existed amongst individuals on their ability and/or willingness to accept their trans* identity. This acceptance may be based upon age at transition (if indeed they did transition – some admitted only cross-dressing in private), physical appearance/body image and perceived social acceptance. For T. Jones et al. (2015), FtM transgender people have traditionally faced issues of invisibility in society based upon the societal perception that transgender people are MTF. T. Jones et al. (2015) found the notions of coming out and remaining stealth[35] were significant in the lived experience of the participants through fear of social exclusion, discrimination and being the possible recipients of violence against them.

Similarly, Couch et al. (2007) argue that negotiating the initial transition was complex. These complexities related to social relationships (societal, familial and intimate) and displacement from their assigned gender. Fear of societal and personal discrimination, denial of gender identity in order to conform to societal expectations, and perceived misunderstandings and familial dispossession were cited as possible explanations for the difficulties in transitioning to the preferred gender. Similar findings by T. Jones et al.

[35] Stealth refers to the notion of being socially invisible and keeping one's gender history secret.

(2015) indicate that relationships with family, friends and partners had a significant influence on wellbeing and quality of life.

Couch et al. (2007) reported that 87.4% of participants experienced social discrimination based upon their gender including refusal of housing (12.3%), employment opportunities (31.6%), and conflicting documentation (32.4%). In their report on LGBT health in the United States of America, Dean et al. (2000) highlighted similar forms of stigma and discrimination for this population which may contribute to significant mental health related issues such as poor self-esteem, depression and anxiety, for example. In their study, Hyde et al. (2014) found that 65% of participants experienced social discrimination and harassment, with 50% of that number in the previous year.

From a mental health perspective, Hyde et al. (2014) reported 57% of the participants had a diagnosis of depression sometime in their life, with 44% currently being treated for depression. On the other hand, Couch et al. (2007) reported that 36.2% of the participants were currently experiencing a major depressive episode.[36] According to T. Jones et al. (2015), 69% of the FtM transgender participants in their study had been diagnosed with depression and anxiety in the previous 12 months. In E. Smith's et al. (2014) study on young people, 47% had a diagnosis of depression, and 45% had a diagnosis of anxiety, three times the national average for this age group (Beyondblue, n.d.). According to the Australian Bureau of Statistics (2007), 4.1% of the general Australian population is affected by depression,

[36] The DSM-5 (American Psychiatric Association, 2013) describes a Major Depressive Episode as a "period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities."

indicating the seriousness of issues surrounding mental health in the trans* population. The Couch et al. (2007) study also found a clear association between discrimination and levels of depression amongst trans* people with those who experienced several forms of discrimination were more likely to report being depressed.

Furthermore, 64.4% of respondents reported modifying their behaviour in a range of social situations (social settings, at work, when using public toilets, with family, at home) to avoid discrimination and that this behavioural modification was linked to depression for MTF trans* people in over 50% of respondents (Couch et al., 2007). However, the research fails to categorise these figures based upon the participants' particular gender expressions (see Footnote 33) which would have enriched the results. The level of behaviour modification to avoid discrimination reported by Hyde et al. (2014) was reported at 76.3% of the participant group; while trans* people are 1.5 times more likely to be diagnosed with an anxiety disorder compared to the general population. Additionally, Hyde et al. (2014) found 20.9% had thoughts of suicide ideation in the previous two weeks. Issues such as diminished employment opportunities, refusal of housing and conflicting documentation contribute to decreased levels of mental health with greater risks of depression, suicide ideation and anxiety disorders. These studies (Couch et al., 2007; Hyde et al., 2014) also suggest that while there has been a significant decrease in social discrimination, there has been an increase in the levels of depression and behaviour modification. Similarly, T. Jones et al. (2015) reported varying degrees of verbal and physical discrimination including assault and public humiliation, although actual numbers were not

reported. In their study on young people, E. Smith et al. (2014) found 66% of the 189 participants reported verbal abuse and 21% had experienced physical abuse based upon their gender presentation.

Experiences of SRS

There has only been one Australian study (Collyer & Heal, 2002) where the focus has been on the experience of SRS. This retrospective study (Collyer & Heal, 2002) reported that in several domains (friendships and social life, employment and finances, and surgical outcome), the majority of participants were satisfied with the results of the surgery and improvement in these domains was experienced. Of the 57 participants, 95% reported improved social relationships, 84% either had no significant change or a positive change in employment and 91% were satisfied with the surgical outcome including appearance, functionality and improved body image. Similarly to Morgan and Stevens (2012), Collyer and Heal (2002) studied trans* women in isolation to the entire population. This approach may not have been avoidable as it is reasonable to assume that there may not have been any trans* men applying for SRS at that surgery at that time for the reason that phalloplasty and metoidioplasty are not available in Australia.

Other Australian studies have included positive and negative aspects of the SRS experience as part of their findings (Couch et al., 2007; Hyde et al., 2014; T. Jones et al., 2015; Riggs & Due, 2013). SRS was found to be linked to better mental health outcomes (Couch et al., 2007; Hyde et al., 2014; Riggs & Due, 2013) while T. Jones et al. (2015) reported that 97% of the participant group experienced an improvement in their day to day life and to their emotional state (regardless of the aesthetics or functionality of the

surgical result). Surgeries included mastectomy, chest surgery and genital surgery. Similarly, Couch et al. (2007) found an improvement in wellbeing following surgical intervention. The majority of the Australian literature indicated satisfaction with the surgical (Collyer & Heal, 2002; Couch et al., 2007) or physical interventions (T. Jones et al., 2015). Negative experiences with SRS were found mainly to be associated with access to, and availability and cost of SRS (Couch et al., 2007; Hyde et al., 2014; T. Jones et al., 2015), especially for trans* men (T. Jones et al., 2015). One study (Couch et al., 2007) noted one participant was depressed following surgery. However the reasons for the depression were not expanded upon in the report. Additionally, this survey is limited by its non-specificity to postoperative trans* people, which was the main focus of the current research.

Experiences with the healthcare system

At the systemic level, negotiating the health care system was an important area identified in several studies (Couch et al., 2007; Hyde et al., 2014; T. Jones et al., 2015; Riggs & Due, 2013). This aspect is especially so in Australia where negotiating systems involves several tiers of government. The majority of this literature (Couch et al., 2007; Hyde et al., 2014; Riggs & Due, 2013) found that 'gatekeeping' was an issue for its participants. However, in contrast, for T. Jones et al. (2015), it was the lack of knowledge of healthcare providers (psychiatrists, GPs and endocrinologists) on trans* men's issues and the access to trans* appropriate services. Furthermore, the need to educate doctors on trans* issues was perceived as a negative experience (Hyde et al., 2014; T. Jones et al., 2015; Riggs & Due, 2013). From a different perspective, Couch et al. (2007) found that learning about

trans* issues could be achieved through collaboration between trans* people and healthcare providers. Finally, Hyde et al. (2014) and Couch et al. (2007) described the lack of appropriate access to services, being treated as someone with a psychopathological disorder, having to justify their 'living' circumstances to be treated fairly and the lack of funding for a medical condition which, anecdotally among Australian trans* networks, is perceived as congenital. One study (Couch et al., 2007) noted that one participant was depressed following surgery. However the reasons for the depression were not expanded upon in the report. Additionally, this survey is limited by its non-specificity to postoperative trans* people, which was the main focus of the current research. With this limitation, the study failed to understand the nuances of the trans* condition and further highlights the significance of the need for the current project with its focus on SRS specifically, as postoperative trans* people are a unique subset of the population. Additionally, due to the online nature of the survey, it is impossible to ascertain the veracity of the identity of the participants, as they self-selected. Indeed, Couch et al. (2007) noted that the study was limited for the very reason that it was unclear how representative the sample was. The study included both trans* men and women, however, which could be seen as a strength. Nonetheless, it is highly unlikely that cisgender people would complete the survey.

It is a valid research outcome to report that trans* people are satisfied with their surgeries and that social and physical functioning has improved for the majority of the participants of those studies since undertaking SRS. It is equally valid that adverse events such as depression and social

discrimination are reported. In the context of the current study, the purpose was to explore the perceived needs and experiences of the participants as they related to the surgical process. From the above review, which situated Australian trans* identities, it is evident there is a paucity of research in the Australian context which has sought to understand the meanings that trans* men and women construct in relation to those processes. In contextualising the trans* experience in Australia, identity is more than a personal journey; it is a socially constructed journey. In the following section, the formation of identity from a medical perspective is examined. It is argued that the transitioning process can be manipulated for medical purposes and as a result, trans* peoples' identities are constructed in ways which impact upon their everyday experiences.

2.3.3 Iatrogenically induced identity development

In the previous chapter, the concept of the psychopathologisation of transsexualism was introduced, whereby, from the middle of the 20th century, case reports of transsexual individuals were published and these individuals were labelled as social psychopaths (Cauldwell, 1949). Cauldwell (1949, p. 275, emphasis in original) contended that "when an individual is unfavourably affected psychologically determines to live and appear as a member of the sex to which he or she does not belong, such an individual is what may be called a *psychopathic transsexual*."

This assumption of the trans* phenomenon as a psychiatric condition based upon individual case reports such as Cauldwell's (1949) report manifests itself as the dominant discourse over the ensuing decades. This discourse exists throughout the entire transition process from the initial

assessment to possible reassignment all in the guise of providing "procedures which alleviated the suffering of transsexuals" (Denny, 2004, p. 27) and which culminated in Benjamin's (1966) treatise into the phenomenon that is transsexuality.[37] In this seminal work, Benjamin challenged the dichotomous concepts of male and female but persisted with the interchangeable concepts of sex and gender.[38] Interestingly enough, the binary nature of gender carried through into the SOC [Version 1] (WPATH, 2011b, p. 1) which was primarily concerned with the "hormonal and surgical reassignment of gender dysphoric persons", as previously discussed.

Moreover, this work (Benjamin, 1966) contributed to the medicalisation of the condition and provided a neat 'script' for trans* people to learn to obtain the desired result of SRS. For example, Benjamin (1966, p. 19) categorised 'true' transsexuals into two distinct types (Appendix F). In order to be classified as a 'true' transsexual, the 'script' assumed that a trans* woman was at least a female "trapped in a male body" who received "insufficient relief from dressing", to a female with "total psychosexual inversion" who "despises his male sex organs" and has a "danger of suicide or self-mutilation, if too long frustrated."

Arguably, the trans* population seeking SRS was being socially engineered to conform to this medical regime and they complied because it gave them some legitimacy in a world which previously disregarded them (Denny, 2004). In an Australian study previously described, Couch et al (2007, p. 34) found that some participants were aware that health

[37] Transsexuality is the experience of being a transsexual.
[38] The terms sex and gender were generally thought of to be the same concepts in an ideal heteronormative world. For Benjamin (1966), sex and gender were decided at conception.

practitioners were in a position of power to control their clients' access to health services such as drug therapy and surgical interventions and this attitude towards health care delivery compelled those participants to "fit a textbook description" in order to proceed through the 'gate'.

The findings of that Australian study (Couch et al., 2007) are also reflected in the writings of Australian medical practitioners, Meese (1997) and Damodaran and Kennedy (2000), who describe the 'gatekeeper' roles of the GP and the Monash Medical Centre Gender Dysphoria Clinic[39] respectively. Moreover, Damodaran and Kennedy (2000) described the power of the multidisciplinary team in deciding the fate of clients' suitability to the gender program. More recently, in a work that espouses radical law reform measures in the USA, Spade (2011, p. 123) sums up this concept by stating that "the medicalization of trans identities forces trans people to conform to rigid disciplinary gender norms in order to access medical technologies if we want or need them." This approach concretises Benjamin's (1966) trans* scripting for 'true' transsexuals (Appendix F), as previously discussed.

This social engineering occurred at a different level in a prospective controlled study on psychological and social change following SRS for a group of MTF transsexuals (Mate-Kole, Freschi, & Robin, 1990). In this English study, forty MTF transsexuals who had been approved for SRS were randomly assigned into two reasonably homogenous groups of twenty. According to Mate-Kole et al. (1990), this homogeneity was based on the

[39] Monash Medical Centre Gender Dysphoria Clinic and its earlier derivatives (Queen Victoria and Royal Park Hospitals) have been operational in Melbourne since the early 1950s and is one of the largest GD Clinics in the Southern Hemisphere.

rating of mental health issues using the Crown Crisp Experiential Index[40] (CCEI) during the clients' assessment for surgical suitability.

All candidates were deemed suitable for surgery based upon their psychiatric evaluations. In this study (Mate-Kole et al., 1990), one group was offered SRS with a short three month waiting period. The control group was to proceed as determined by the treating clinic (normally up to five years from first attendance to surgery). This length of treatment as the 'norm' appears excessive given that the then SOC [Version 3] (WPATH, 2011b) suggests a period of six months psychotherapeutic interventions and twelve months day to day living in the preferred gender.

According to the authors (Mate-Kole et al., 1990), when the two groups were re-examined two years later, significant changes in mental health were noted in the control group, including an increase in neuroticism and adverse outcomes associated with social functioning (employment and sexual activity). This abuse of power in the name of clinical research brings forth questions on what ethical protocols, if any, were used to justify this type of research by withholding surgery to a group of suitable candidates. It should be noted that details of ethical approval were omitted from the article, and indeed the purposes of the study were not articulated.

This section discussed how trans* identities have been manipulated through the medicalisation of transsexualism from the mid-20th century and the need for trans* people to conform to a prescriptive process in order to

[40] Crown Crisp Experiential Index is an internationally validated tool to measure different kinds of neurotic traits and symptoms. The tool measures anxiety (free-floating, somatic and phobic), obsessionality, depression and hysteria (Mate-Kole et al., 1990).

proceed through the ‘gates’ held closed by medical practitioners. The ‘gatekeeper’ model also raised ethical issues in reference to clinical research which resulted in adverse outcomes for some trans* identities. This top-down approach can only affect the psychosocial well-being of trans* people as they transition. The discussion now turns to one particular aspect of the psychosocial journey which inspired this research; the trans* person’s lived experiences of loss and grief. The journey is characterised by multiple losses and these are discussed below.

2.3.4 Loss and grief

Conceptually, loss and grief are universal phenomena intrinsically linked to the human condition and are continually encountered by health professionals in a multitude of situations (Cowles & Rodgers, 1991). Loss has been described as “the condition of being deprived of something or someone” (Emanuel, Ferris, von Gunten, & Von Roenn, 2011, p. 1) and the grief reaction to the loss (perceived or real) invokes intense emotions which are symbolically linked to that loss due to “changes to our experiences of self, the world, and the future” (Love, 2007, p. 1). For trans* people, the paradigm shift from one gender to another involves multiple losses throughout the journey, both preoperatively and postoperatively.

Preoperatively, losses are associated with personal identity and personal relationships (Bockting et al., 2006; Irwin, 2002; Korell & Lorah, 2007; Lev, 2006; Zandvliet, 2000). According to Korell and Lorah (2007), personal identity comes under scrutiny during puberty when secondary sexual characteristics begin to develop. For all teenagers, puberty is a defining moment. As argued elsewhere, for the trans* person, as the body

begins its metamorphosis to adulthood, an “inherent sense of difference to everybody else” becomes more obvious (Chaplin, 2011, p. 103). According to Korell and Lorah (2007), losses at this stage of development are associated with the physical body betraying the psychological body. Similarly, Irwin (2002) acknowledges that a sense of loss of identity occurs in this preoperative phase when transitioning and adjusting to ‘living’ as another gender. Resultant losses may include loss of income and employment (Bockting et al., 2006). In a report on Lesbian, Gay, Bisexual and Transgender (LGBT) health in the United States, Dean et al. (2000) argued that trans* people are socially and economically marginalised because of their gender.

One Dutch epidemiological and demographic study (van Kesteren, Gooren, & Megens, 1996), conducted retrospectively from 1975 to 1992 using clinical historical data of 1285 (949 MTF and 336 FTM) patients, noted that these economic, familial and peer group losses were associated with being a late onset transsexual and regretting (5 of the MTF clients regretted the surgery) the decision to undergo SRS. The authors based their findings on those clients who remained in ongoing contact with the unnamed clinic in the Netherlands over the study period. According to van Kesteren et al. (1996), their study was purely numerical in nature and did not provide any understanding of the phenomenon. This study addresses the issues surrounding the understanding of the trans* phenomenon as it relates to the surgical process for its participants.

In an Australian study previously described (Collyer & Heal, 2002), employment losses following SRS were also associated with the age of the

person. Prior to surgery, 74% (n = 42) of the 57 participants were employed. This number reduced to 67% (n = 38) following SRS. However, these losses mostly related to those transsexuals who became pensioned (disability and aged) following surgery.

On the other hand, it is apparent that the transition is more than a journey traversed by the transsexual person as an individual. It is a social process that involves not only family and friends (Denny, Green, & Cole, 2007), but the wider social network (Lev, 2006) including the cultural and spiritual communities to which they belong (Bockting et al., 2006). According to some authors, losses associated with social relationships can be temporary or permanent (Korell & Lorah, 2007) as both the individual and their social circle (especially the family) adjust to the transition. Beyond the losses associated with social networks are those at a societal level due to the minority status of trans* people and the reactions of society at large. In particular, there is the sensationalist treatment of trans* people in the media, where trans* individuals have been represented as victims to be blamed for their existence and demise (Chamberlin & Brennan, 2014, October 7).

For example, through interviews with their trans* clients' families, Emerson and Rosenfeld (1996) considered the adjustment process of family members when confronted with the 'coming out' of a trans* relative. As Emerson and Rosenfeld (1996) suggest, families may experience feelings of loss and grief as they come to terms with the reshaping identity of that person. This approach suggests that the adjustment process was varied amongst families and individuals and depended upon the functional status of the family unit prior to transition.

From a postoperative perspective, Bockting et al. (2006, p. 62) state that both MTF and FTM transgender clients may feel grief following surgery in relation to their physicality due to “pain, surgical complications, or changes to sexual function.” Furthermore, the authors state that this grief may be synonymous with dissatisfaction and regret. In an Australian study on transgender wellbeing (Couch et al., 2007), of the 48 participants who received a vaginoplasty, several participants (actual number unknown) reported feelings of loss and grief in the postoperative phase of their treatment. The reasons for these feelings remained unexplained in the report. It is therefore apparent that experiencing loss and grief are important psychosocial components of the trans* experience for some individuals.

It is well documented that surgery that involves amputation/bodily mutilation gives rise to feelings of loss (Cowles & Rodgers, 1991; Jillings, 1985; Kelly, 1985). Furthermore, there is evidence to suggest that surgical patients who are expected to experience an improvement in bodily function, such as in cardiac surgery, still experience extreme psychological trauma. In their prospective study of 71 cardiac surgery patients, Oxman, Barrett, Freeman and Manheimer (1994) found that 51% of the patients in the study developed an adjustment disorder following surgery and as many as 30% reported continued impairment six months after the surgery. Those feelings of loss not only affect the recipients of care, but can equally affect donors in the case of organ transplantation (J. Brown et al., 2008). Participants in that phenomenological study described the emotional impact of donating kidneys to loved ones, and the feelings of loss and grief they experienced as a result, preoperatively and postoperatively. Therefore, it is not surprising that

anticipating the physical loss is overlooked in the SOC [Version 7] (WPATH, 2011a) as SRS is still regarded as the most effective treatment (Collyer & Heal, 2002; de Cuypere et al., 2005; Meyer et al., 2001; Michel, Ansseau, Legros, Pitchot, & Mormont, 2002; WPATH, 2011a), and is part of the healthy process towards psychological and physical fulfilment for MTF transsexuals in particular (as cited in Martin & Yonkin, 2006).

Alongside loss and grief, this review provided a contextual examination of the literature relating to the primary care needs of trans* people and their identity development from both a personal and medical perspective. The review highlighted a significant gap in the research of the trans* experience from a qualitative perspective; understanding the meanings that trans* people construct in relation to their life experiences, and in particular, the surgical process. An important component of the existing literature relates to the SOC (WPATH, 2011a, 2011b) for the reason that one of the aims of this study was to explore the implications of the findings in this study in relation to the SOC with a view to suggesting enhancements to those guidelines. For that reason, the following discussion is devoted to a detailed description of the entire seven versions of those guidelines from their inception in 1979 to their most recent format in 2011, and provides an important background synopsis for a detailed analysis in relation to the participants' experiences in Chapter 6.

2.4 THE STANDARDS OF CARE FOR TRANS* AND GENDER DIVERSE PEOPLE

> In recent decades, the demand for sex-reassignment has increased, as have the number and variety of possible psychologic, hormonal

> and surgical treatments. However, until present, no statement on the standard of care to be offered to gender dysphoric patients (sex-reassignment applicants) has received official sanction by any identifiable professional group. (WPATH, 2011b, p. 1)

2.4.1 Background

The SOC (WPATH, 2011a, 2011b) detail the international guidelines for the assessment and treatment of trans* and gender diverse people. Therefore, it is necessary to review the guidelines in order to explore those implications from the findings of this study. In this section, the evolution of the SOC [Versions 1-6 and Version 7] (WPATH, 2011a, 2011b) is discussed. SRS is a mainstream medical treatment designed to minimise the feelings of gender dysphoria for some individuals diagnosed with GD (American Psychiatric Association, 2013). GD was originally introduced as a diagnosable mental disorder in the DSM-III under the title of Transsexualism, as previously noted (American Psychiatric Association, 1980). It should also be noted that transsexualism is also classified by the World Health Organisation (WHO) in the ICD-10[41] as a mental and behavioural disorder (World Health Organisation, 1993).

The impending introduction of the DSM-III classification saw the need for an international organisation to provide ongoing evidence-based, professional guidance for clinicians in the field on the treatment of those diagnosed with this stigmatised mental disorder. Clinicians in the field were also lobbying for a set of standards in relation to the provision of SRS due to

[41] The International Classification of Mental Disorders -10' (World Health Organisation, 1993) definition of transsexualism broadly aligns with that of the DSM-III (American Psychiatric Association, 1980). In 2017 the ICD-11 is due for release where that classification is expected to change from its current psychopathologising focus.

the lack of evidence available on the applicability of SRS as a treatment option (WPATH, 2011a). The ensuing documents dealing with the complex issue of gender dysphoria are based on the original work of Dr Harry Benjamin (1966).

Dr Benjamin (1885-1986), a German physician and endocrinologist became interested in this field when he met a young gentleman who insisted he was a girl (Archive for Sexology, n.d.). This chance meeting through a scientific colleague (Alfred Kinsey)[42] led to the eventual formation of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) which developed the first SOC in 1979. It needs to be noted upfront that much of the knowledge applied to the initial treatment of transsexualism in those early days was based upon individual case reports and expert opinion.

2.4.2 Hormonal and surgical sex reassignment and beyond: an evolutionary description

Version 1 – February, 1979

As indicated, the development of the SOC [Version 1] (WPATH, 2011b) was directly in relation to the proposed inclusion of transsexualism into the DSM-III[43] (American Psychiatric Association, 1980) as a mental disorder. The main purpose of the original document was to provide a minimum set of

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[42] Alfred Kinsey (1894-1956) was an American sexologist and one of the first scientists to conduct studies into human sexuality. He was responsible for the Kinsey Scale (from homosexuality to heterosexuality) which was adapted by Benjamin to become the Sexual Orientation Scale in Benjamin's work (see Appendix E for an adapted version relating to transsexuals).

[43] The DSM-III, category 302.5x (as cited in WPATH, 2011b, p. 3) provided the following criteria for a diagnosis of transsexualism, based upon the 1978 printing of the proposed DSM-III:

A. Persistent sense of discomfort and inappropriateness about one's anatomic sex
B. Persistent wish to be rid of one's own genitals and to live as a member of the other sex
C. The disturbance has been continuous (not limited to periods of stress) for at least two years
D. Absence of physical intersex or genetic abnormality
E. The disturbance is not symptomatic of another mental disorder, such as Schizophrenia

See Table B1 for the actual criteria as published in the DSM-III (American Psychiatric Association, 1980).

requirements for hormonal and surgical[44] sex reassignment of gender dysphoric people in order to improve their quality of life. These minimum requirements existed in relation to both the patient and the psychiatrists and psychologists responsible for the diagnosis.

Interestingly enough, at this stage of the evolution, the term gender dysphoria was limited in its focus as it only applied to "sex-reassignment applicants" (p. 1). Its direct alignment with the proposed DSM-III (American Psychiatric Association, 1980) assumed that only those interested in hormonal and surgical sex reassignment could or would be classified as transsexuals (sex-reassignment applicants) based upon the previous work of Benjamin (1966) and therefore excluded transvestites[45] and transgenderists[46] or those individuals who were reassigned or had their sex renounced in childhood [intersex people] (WPATH, 2011b, p. 2).

The principles and standards of Version 1 (WPATH, 2011b) indicated several key points which underpinned what was then known on SRS, including its irreversibility and the possibility of postoperative regret (despite a positive diagnosis of Transsexualism). Because of these factors, it stipulated that hormonal and surgical reassignment cannot be classified as elective procedures which in turn required continuous and careful psychiatric and psychological evaluation. This approach reinforces the medical and social control as previously discussed.

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[44] Surgical sex reassignment referred to both genital (including breasts) and non-genital surgeries (including facial and other body parts, hips for example).
[45] A transvestite is an individual who dresses or has thoughts of dressing in the opposite gender mainly for sexual pleasure and excitement (American Psychiatric Association, 2013). In the main, these individuals are heterosexual males.
[46] It was assumed that transvestites and transgenderists were not SRS applicants.

The proposed DSM-III (American Psychiatric Association, 1980) also recognised the possibility that individuals with other disorders such as schizophrenia may have delusions of being the opposite gender. Additionally, it was noted that depression and anxiety were often commonplace in transsexuals. Therefore, the SOC [Version 1] (WPATH, 2011b) stated that other psychiatric conditions should be treated first before any substantive diagnosis of transsexualism could be made.

Moreover, due to the major nature of those hormonal and surgical interventions, the SOC [Version 1] (WPATH, 2011b) indicated that diagnosis may only be made by psychiatrists and psychologists who were professionally experienced in sexual disorders (and disorders of gender in particular). Additionally, any recommendations to 'offer' under the "gatekeeper" model hormonal and surgical interventions were based in part upon that diagnosis and successful social functioning and acceptance through living as the preferred gender in a fulltime capacity. The sequence of living as the 'opposite' gender, hormonal and finally surgical therapy later became to be known as triadic therapy in Version 5 (WPATH, 2011b). Table 2 indicates the minimum timeframes in relation to these interventions. The time frames assumes living as the 'opposite' gender for the specified time in a full time capacity and functioning successfully in that role.

Table 2

Hormonal, Genital and Non-genital Sex Reassignment Minimum Timeframes Standards of Care Version 1, 1979

Standard Number	Item	Minimum Time Frame
Standard 4	Initiation of hormonal sex reassignment	3 months
Standard 5	Non-genital sex reassignment (facial, hip, limb, and so on)	6 months
Standard 6	Genital sex reassignment	12 months

Note. Adapted from "Standards of Care v1-6 (WPATH, 2011b).

An interesting aspect of this initial approach existed in relation to Standard 5 of the guidelines in that it restricted a trans* person from any type of body modification without first having approval to do so. This type of restriction implies that trans* people do not have the mental capacity or the power to make their own decisions about their own bodies. No such restrictions existed in relation to biological men and women from obtaining plastic surgery such as rhinoplasty, for example.

It could be interpreted that the needs of the transitioning person were sidelined in favour of regulation. Moreover, according to Goffman (1963, p. 9), these restrictions are a form of social stigma as they refer to "the situation of the individual who is disqualified from full social acceptance" by virtue of his/her deviance from socially accepted norms. This particular aspect is further complicated when that deviance is perceived as a pathological illness. The social structure as defined by the biomedical model assumes the 'sick' person's role is to forgo normal social responsibilities and cooperate with the medical practitioner (Parsons, 1951). This combination of the stigma of the individual and the social role of the patient reflects the view that the deviant "is not quite human" (Goffman, 1963, p. 15).

The original guidelines (WPATH, 2011b) also indicated several physical factors associated with the transition process. These included the irreversible side effects of taking hormone therapy such as voice disturbance, hair growth and the like. Additionally, it noted the need to carefully monitor the levels of hormone (testosterone in FTMs and oestrogen in MTFs) to ascertain correct dosages. A plethora of other blood tests were also recommended. In addition, for those approved for surgery, a urological examination was recommended to determine any undiagnosed genito-urinary complications which may affect the surgery due its complicated nature.

As previously indicated, minimum standards also applied to the medical professionals responsible for providing a diagnosis of transsexualism and the 'offer' of hormonal and surgical reassignment (WPATH, 2011b). These requirements intended to protect both the clients and the health professionals by ensuring a system of peer review to oversee the diagnosis and offer of genital sex reassignment.[47] The system required at least one of the diagnosing team to be a psychiatrist, and a second opinion obtained (psychiatrist or psychologist) to endorse the decision to offer the proposed treatment. Furthermore, the guidelines suggested that the multidisciplinary team shared a moral responsibility for their decisions to offer hormonal and/or surgical treatments.

[47] Genital sex reassignment was described as being any of the following: penectomy, orchidectomy, castration, vaginoplasty, mastectomy, hysterectomy, oophorectomy, salpingectomy, vaginectomy and phalloplasty (WPATH, 2011b).

Version 2 – January, 1980

Less than twelve months following the release of Version 1, Version 2 was published (WPATH, 2011b) which aligned with the publication of the DSM-III in February 1980 (American Psychiatric Association).

There were three fundamental changes to the original draft, the first of which reflected the view of the DSM-III (American Psychiatric Association, 1980). In this version, the original definition of gender dysphoria was expanded to ***not*** exclude transvestites and transgenderists. It stated in the DSM-III (American Psychiatric Association, 1980) that in rare cases, some individuals diagnosed previously as transvestites may eventually be diagnosed as transsexuals. However, it is possible these individuals were transsexuals who denied their true identity development for social and/or cultural reasons (to cross-dress in private attracts no public stigma).

The second change related to the timeframes for hormonal and non-genital surgical procedures (See Table 2). There was no longer any requirement for applicants to live as the 'opposite' gender for a minimum time to receive hormonal treatment or to modify the non-genital parts of their bodies. The need for hormonal therapy would now be based upon psychological and/or psychiatric evaluation alone. This approach accommodates individuals who may not be able to live as the 'opposite' gender without first receiving the intended therapeutic effects of hormone therapy (more or less facial hair, for example). Similarly, non-genital surgical procedures, which now included reconstructive or cosmetic breast surgery[48]

[48] While the SOC indicated this change to include breast surgery as non-genital ((American Psychiatric Association, 1980, pp. 27, [Footnote]), the definitions provided in Versions 2, 3, 4, 5, 6

was negotiated between the surgeon and the client and arguably, this is a positive change because it reduces the stigma and provides the patient with some autonomy which was previously denied in the earlier version.

These changes to the timeframes prompted a change in the overall definition of the SOC (WPATH, 2011b, p. 11). According to WPATH (2011b), at the time, there was considerable debate on these time parameters due to variable medical opinion (some 'experts' on GID recommended longer timeframes) and the unknown long term biopsychosocial impact of the procedures involved, including surgery. These unknowns were also noted in the DSM-III in reference to SRS due to its relatively recent history as a medical procedure (American Psychiatric Association, 1980, p. 262). As a result of these changes and the variable medical opinion which existed and the lack of solid scientific evidence, the definition now included a recommendation that all exceptions to the standards be carefully documented.

Version 3 – March, 1981

Changes made in Version 3 (WPATH, 2011b) existed in relation to the nomenclature, status and competency of health professionals responsible for a diagnosis of GID, psychotherapy and recommendation of SRS. In the first instance, the terms 'psychiatrist' and 'psychologist' were replaced by 'behavioral scientist' [sic]. The level of the degree obtained (doctoral or masters) was the benchmark from which recommendations for both hormonal therapy and SRS could be made. Hormone therapy could be

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and 7 (WPATH, 2011a, 2011b) reflected the view that breast modification was still included as genital surgery and would require a behavioural scientist recommendation.

recommended by either a doctoral[49] or masters level person. However for SRS, one of the two recommendations must be made by a doctoral level person.

Moreover, these guidelines (WPATH, 2011b, p. 20) indicated the level of competency required. It was expected that behavioural scientists have documented and proven experience (not necessarily certified or credentialed) in a broad range of mental health conditions, in addition to sex and gender therapy. This competence could be demonstrated by the behavioural scientists' inclusion in a regulatory body at State level, or nationally certified professional association.

Version 4 – January, 1990

Version 4 (WPATH, 2011b) was published approximately two years following the release of the DSM-III-R (American Psychiatric Association, 1987) to reflect the change in the diagnostic criteria for a diagnosis of transsexualism under category 302.5x, which had changed substantially from the original classification in DSM-III (See Table B1) (American Psychiatric Association, 1980).

This version (WPATH, 2011b, p. 39) included transvestites (in comparison to Version 2 which did *not* exclude them) and "effeminate male homosexuals and masculine female homosexuals." This interpretation was informed by these persons' histories and aligned more with the DSM-III (American Psychiatric Association, 1980). As previously described, the

[49] Doctoral level included: Doctor of Philosophy, Doctor of Education, Doctor of Science, Doctor of Social Work, Doctor of Psychology and Doctor of Medicine (WPATH, 2011b, p. 26).

DSM-III (American Psychiatric Association, 1980) noted that some individuals diagnosed as transvestites later evolve into transsexuals.

The only other change in Version 4 (WPATH, 2011b, p. 42) existed in relation to the requirement for approved applicants to have a urological examination prior to obtaining SRS. This requirement was rescinded in January 1990. However, this particular aspect seems peculiar in that the principle underlying this standard remained in the document. That principle recognised the extent of the surgery on the genito-urinary tract and the inherent risk of complications during surgery if these pre-existing urinary conditions were left undiagnosed.

Version 5 – June, 1998

This version, the first to include a brief reference guide (WPATH, 2011b), was developed in response to the publication of the DSM-IV (American Psychiatric Association, 1994) which replaced the mental disorder known as transsexualism with GID.[50] It recognised that GID was not one specific disorder, but part of a range of 'disorders' that may begin in childhood, that do not necessarily result in an individual undertaking SRS as the final transition. Therefore, the guidelines included sections on diagnosis and treatment options for children and adolescents.[51]

Additionally, Version 5 (WPATH, 2011b) recognised that treatment is not necessarily sequential following a rigid pattern of "cross-gender living,

[50] The World Health Organisation (1993), in its International Classification of Diseases – (ICD-10) introduced transsexualism as one of five diagnoses for GIDs. The other diagnoses included:

I. Dual-role transvestism
II. Gender Identity Disorder of childhood
III. Other Gender Identity Disorders, and
IV. Gender Identity Disorder - unspecified

[51] The diagnosis and treatment of children and adolescents is beyond the focus of this review, and therefore will not be covered.

administration of cross-sex hormones, and genital (and other) surgeries" (WPATH, 2011b, p. 56). Indeed, other forms of gender dysphoria exist in persons, whose gender expression does not conform to the binary gender code, including effeminate male homosexuals, masculine women, female impersonators and so on. In consideration of the above, interventions offered (psychological, endocrinological and surgical) were to provide client centred outcomes conducive to the individual's personal well-being and self-fulfilment. Moreover, the guidelines iterated the flexibility to treat clients according to this triadic regime, where psychotherapy may be used to educate and inform the trans* person of various life issues they may encounter. It is for this very reason that Version 5 (WPATH, 2011b) introduced the Real-Life Experience (RLE). The RLE can be described as that period of time where an individual consolidates their new gender role by living in that role in a full time capacity (WPATH, 2011b). The RLE is considered as part of the evolution of the transitioning individual as they face various personal and social issues.

It introduced parameters by which the mental health professional and the client could assess the trans* person's ability to function socially in their preferred gender.[52] However, the guidelines note that the RLE is not a test of transsexuality, but more a test of the capacity to succeed and function; to

[52] Parameters of the Real-life Experience include:

A. To maintain full or part-time employment
B. To function as a student
C. To function in community-based volunteer activity
D. To undertake some combination of items 1-3
E. To acquire a new (legal) first or last name
F. To provide documentation that persons other than the therapist know that the patient functions in the new gender role

Adapted from Version 5: (WPATH, 2011b, p. 68)

provide a bridge from which future directions can be determined. For the trans* person whose goal is SRS the sequence could be either of the following:

- Hormones > Real-life Experience > Surgery, or
- Real-life experience > Hormones > Surgery.

In recognition of the changing attitudes towards the non-binary nature of GID and the introduction of the RLE, the eligibility criteria for both hormonal and surgical reassignment were changed to reflect this aspect. In order to qualify for hormonal therapy, an individual must complete either three months RLE or a minimum of three months psychotherapy. This change, in effect, saw a combination of the approaches used in Versions 1 and 2, as previously described. Additionally, the guidelines noted that in some extreme cases, hormone therapy may be given without the need for RLE or surgery if they were diagnosed with GID and maintained psychotherapy for the minimum three months.

The eligibility criteria for SRS saw the requirement of both twelve months continuous hormone therapy without medical contraindication and twelve months continuous and successful RLE (and if necessary, psychotherapy as determined by the mental health professional). Although the need for psychotherapy was determined by the mental health professional prior to SRS, the psychotherapeutic process was promoted as a collaborative effort between the client and the mental health professional in order that a trusting therapeutic relationship is formed. However, the guidelines allowed some flexibility for those individuals who had been living in their preferred gender for many years without the need for hormonal therapy

if they underwent a period of psychotherapy (no time frame mentioned) to determine their suitability and readiness for SRS.

Version 5 (WPATH, 2011b) introduced the concept of ethics into the SRS phenomenon. It was noted that many people (medical and non-medical alike) oppose the surgical treatment of GID because the surgery involves the removal or modification of otherwise 'normal' body tissue and is seen by those people as not enhancing a more positive self-image in comparison to other plastic surgeries. In my opinion, those personal opinions hold no validity in the discourse for the reason that cisgender people can modify their body parts without recourse to their supposed normality. It concluded that consideration be given to the psychological distress faced by individuals with GID when medical professionals take this contrary approach.

Version 6 – February 2001

Version 6 (WPATH, 2011b) coincided with the then recent publication of the DSM-IV-TR (American Psychiatric Association, 2000). The main focus of the DSM-IV-TR (American Psychiatric Association, 2000) was to substantiate already existing information based upon empirical data. No substantive changes were made to existing diagnoses in the DSM-IV-TR. In light of this, changes within Version 6 were mainly textual in character. For the purpose of this review, these changes will not be covered unless they directly relate to the triadic therapy (RLE, hormones and surgery).

One parameter of the RLE was changed to clarify its requirement. There was now a requirement to change your given name to one that was gender appropriate. Previously, an individual was required to "acquire a new (legal) first or last name" (WPATH, 2011b, p. 68). Additionally, the

requirement to undertake either three months RLE or a minimum of three months psychotherapy for the provision of hormone therapy was 'softened' at the discretion of the clinician if, for example, there was concern that the client would obtain 'black-market' medication and therefore be unsupervised in the use of the drugs.

Although not an absolute requirement, Version 5 (WPATH, 2011b, p. 77) suggested a doctoral level behavioural scientist re-evaluate an individual's readiness for surgery two weeks prior to the scheduled surgery if that person has a comorbid psychiatric disorder such as schizophrenia or borderline personality disorder. This section of the guidelines was deleted in Version 6.

Version 7 – September 2011

The intent of the current SOC [Version 7] (WPATH, 2011a) is to provide a flexible set of clinical guidelines for the health care needs of those individuals that identify as transsexual, transgender and gender nonconforming. It recognises that gender expression goes beyond the binary notion of gender, and indeed in some instances may not result in psychological, hormonal or surgical interventions. In consideration of this aspect, treatment is individualised to the gender identity needs of the client which may include helping the client find whereabouts their gender identity fits along the entire gender continuum. In addition, the movement to these individualised treatments prompted a shift towards an 'Informed Consent Model'[53] of treatment (WPATH, 2011a, p. 35) by recognising that these types

[53] The SOC [Version 7] (WPATH, 2011a) still operates from the perspective that it places greater emphasis on the provision of mental health services at the discretion of the mental health professional.

of protocols are “consistent with the guidelines presented.” This shift only applies, according to the guidelines, to the provision of hormone treatment in a multidisciplinary environment (WPATH, 2011a, p. 36).

The guidelines (WPATH, 2011a) recognise the fluidity of gender identity along that continuum and the multiplicity of outcomes from male to female and female to male which may never stabilise. This recognition resulted in a change of direction for the SOC as SRS was no longer seen as the final or only valid outcome. It was merely an option. Therefore, the triadic therapy which was the mainstay of previous versions no longer existed in its original form. Treatment options now included expressing gender and role in a way that was individually appropriate as well as hormonal, surgical and psychotherapeutic treatment modalities. This individual approach to gender expression and role could include living full or part time in the preferred, or indeed not at all.

As more children are questioning their gender from an earlier age and puberty-suppressing hormones are contributing to better outcomes, the guidelines (WPATH, 2011a) included greater detailed information on the criteria for providing such treatments. For example, in a prospective follow-up study (de Vries, Steensma, Doreleijers, & Cohen-K, 2010) of 70 adolescents who received puberty suppression therapy from 2000-2008, all participants had improved psychological functioning over the duration of the therapy with no loss to follow-up and continued onto hormonal therapy when eligible to do so.

The notion of the ‘Informed Consent Model’ places greater emphasis on the provision of the service. Assistance with mental health issues are at the request of the individual (unless comorbid mental health issues are impeding progress in identifying an appropriate gender identity).

Previously, little emphasis was placed on the effect on the gender dysphoric individual's social circle, including family and other social support mechanisms. Version 7 of the guidelines (WPATH, 2011a) recognised the effect that changing gender roles may have upon this social network and that therapy (group and individual) may be necessary to cater for the changing circumstances of the family. All members of extended family network and other relationships may require adjustment to processes associated with the transition including coming out and sexual health (Emerson & Rosenfeld, 1996; Lev, 2006).

Included for the first time is a section on reproductive health (WPATH, 2011a, p. 50). This new section particularly applies to those individuals who undertake hormonal and/or surgical therapies as it was recognised that some trans* people wish to exercise their innate human right/need to reproduce. The inclusion of this area was based upon an international survey which aimed to explore the opinions of trans* women on reproduction (de Sutter, Kira, Verschoor, & Hotimsky, 2002). The results indicated that 93/121 (77%) of the MTF respondents reported that sperm freezing should be considered and offered as an intervention before commencing hormone therapy. According to WPATH (2011a), not being able to reproduce following surgery is a source of regret for some individuals.

Additionally, the SOC [Version 7] (WPATH, 2011a) included a comprehensive section (in Version 5, a comment to incarcerated individuals was included) on the applicability of the guidelines on those individuals living in institutional environments, including prisons and health care facilities. WPATH (2011a) attest that institutionalised gender dysphoric individuals

have access to appropriate health care similar to that available under usual circumstances. This access could include the provision/maintenance of hormone therapy or approval for SRS and in those cases where no definitive diagnosis of GID has been determined, assessment should take place. The inclusion is based, in part, upon the case reports of 18 incarcerated MTF trans* women at undisclosed locations, three of which had successfully completed auto-castration while incarcerated (G. Brown, 2010) and institutional readiness to exclude treatment on the grounds that Version 6 (WPATH, 2011b) of the guidelines did not include those individuals who had not been previously assessed for their self-diagnosed dysphoria (G. Brown, 2009).

With the release of the DSM-5 in 2013 and the change in nomenclature from GID to GD in that document also prompted the inclusion of those individuals with a Disorder of Sex Development (DSD), some of whom may develop chronic gender dysphoria due to their ambiguous genitalia. The SOC [Version 7] (WPATH, 2011a) will apply to those individuals with an intersex condition.[54]

The guidelines (WPATH, 2011a) recognise the medical necessity for some individuals to be treated with hormonal and/or surgical interventions.[55] Considerable knowledge has been gained in the area of hormonal therapy, including the types of hormones available and treatment modalities (Hembree et al., 2009, p. 3144). For example, it is recommended anti-androgens are prescribed in conjunction with oestrogens for MTF patients.

[54] Intersex conditions or DSDs are beyond the scope of this review and will not be examined.
[55] WPATH (2011a) note the difficulty to evaluate hormone therapy in isolation in relieving GD.

Additionally, evidence exists on the likelihood of the physical risks of taking such medications (Hembree et al., 2009). To illustrate this aspect, venous thromboembolic disease and hypertriglyceridaemia carry a likely increased risk in MTF patients. These risks are expanded on in great detail in the document which enables the client to make an informed choice when the decision to obtain hormone therapy is made and goes some way towards the implementation of the 'Informed Consent Model' (Footnote 53). Additionally, changes to the criteria for hormone therapy were made from Version 5's requirement for three months RLE or three months continuous psychotherapy.[56]

Version 7 (WPATH, 2011a) of the guidelines acknowledges genital surgery as the most scrutinised treatment option for trans* people due to its irreversibility. As the triad of therapies (hormones, RLE and surgery) no longer exists in recognition of the multiplicity of gender identities, roles and expressions, criteria for genital surgery have changed from Version 5 which comprised twelve months continuous hormone therapy and RLE alone specific to the surgery.[57]

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[56] Criteria for hormonal therapy include:

1. Persistent, well documented gender dysphoria
2. Capacity to make a fully informed decision and to consent for treatment
3. Age of majority in a given country (or if younger, following the SOC in respect to children and adolescents), and
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

Adapted from: (WPATH, 2011a).

[57] Criteria for metoidioplasty, phalloplasty and vaginoplasty (the final surgical transitions) include:

1. Persistent, well documented gender dysphoria
2. Capacity to make a fully informed decision and to consent for treatment
3. Age of majority in a given country (or if younger, following the SOC in respect to children and adolescents),
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled,

Finally, the decision to offer surgery to those individuals with comorbid psychiatric issues such as bipolar disorder and borderline personality disorder following a re-evaluation of those conditions was reintroduced in the current version of the guidelines, stating that "no surgery should be performed while a patient is actively psychotic" (WPATH, 2011a, p. 62). This section was previously deleted from Version 6 (WPATH, 2011b) and is based upon recommendations from a literature review of regret, suicide and prognosis with regard to SRS (de Cuypere & Vercruysse, 2009).

2.5 SUMMARY AND CONCLUSION

The position of SRS as a surgical procedure and its relationship to healthcare providers, recipients of care and the SOC in the preceding literature review appears quite clear. SRS remains the one procedure that is highly regulated with its reliance upon in-depth psychological evaluations where eligibility for surgery requires two independent assessments. The primary care of trans* people pursuing SRS is significantly geared towards the physical aspects of the transition (for example, the side effects associated with hormone use, including cardiovascular and osteoporotic comorbidities and the surgical procedure as a procedure). While minimum timeframes are laid down for experiencing everyday life as the intended gender, health professionals scrutinise and manipulate ongoing behaviour to the point of approval for surgery. I argued that this manipulation of personal identity contributes to continued medicalisation and pathologisation and it

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are clinically contraindicated for the individual), and
6. 12 continuous months of living in a gender that is congruent with the patient's identity.

Adapted from: (WPATH, 2011a).
Please note: the criteria for 'lesser' genital surgeries (hysterectomy and orchidectomy, mastectomy or breast augmentation) follow points 1-4 of this guide.

demonstrated how the biomedical model affects personal identity development socially, personally and ethically. Following approval to obtain the surgery, however, this review clarifies that there appears to be little concern for ongoing therapeutic guidance unless requested by recipients of care. From a contradictory perspective, the review clearly demonstrated that identity development goes beyond surgical intervention and that ongoing support following surgical intervention may be necessary.

Thus, it appears to have exposed a gap in care at a time when the most significant and irreversible change is to take place. In particular, from this review into the concept of loss and grief, it is clear that a substantial body of literature exists into preoperative losses and the journeys associated with part of the transition process. However, it also appears that the concept of loss and grief, as it applies to SRS, becomes consumed by physical processes. The possibility that grief is experienced as a consequence of the finality of the surgical procedure is too easily seen as regret, dissatisfaction with the end result or levels of pain experienced and not the lack of preparedness for such experiences to occur. Despite the body of literature acknowledging loss and grief as a major consideration for positive lifesaving surgeries, amputees and organ donors, the literature suggests that such psychosocial processes are of little importance to SRS. However, it could be argued that SRS is both lifesaving and an amputation. This point reflects my argument that the psychosocial needs of SRS recipients may not be well understood which is related to a strong focus on the positive aspects of the surgery such as improved body image and improved life functioning. These emotional processes associated with transition require elucidation.

Contextualising the extent of Australian literature into SRS demonstrated the paucity of research in this field. Research into lives of postoperative trans* identities was limited specifically to one quantitative study (although that study allowed participants to give written qualitative responses) since 2002. Collyer and Heal (2002) provided important statistical information on the phenomenon, they added little knowledge towards the understanding of the phenomenon of SRS as the types of written responses generated by participants typically did not elaborate on issues in great depth and detail. Other Australian studies (Couch et al., 2007; Hyde et al., 2014; T. Jones et al., 2015; Riggs & Due, 2013) included certain aspects of the postoperative experience. However, their focus was not specifically in relation to the experience of SRS. Additionally, T. Jones et al. (2015), although not medically driven, described the FtM experience in isolation to the entire population.

Furthermore, Couch et al. (2007) and T. Jones et al. (2015) noted that there had been limited research into the lives of trans* people in Australia, as did Damodaran and Kennedy (2000) in their article on the evolution of the Monash Gender Dysphoria Clinic. It was therefore important to further understand the experiences of Australian trans* people in order to contribute to existing international knowledge. As WPATH (2011a) notes, the majority of research conducted in this field occurs in North American and Western European contexts and that an international approach is necessary to encompass variations in social and cultural attitudes towards transgenderism.

This research addresses such issues and makes a significant and original contribution to knowledge in the relatively new field of transgender medicine/health and well-being, which is consistent with the goals of WPATH (2011a). It does this through a narrative approach to investigate those experiences. The participants, postoperative trans* men and trans* women living in Australia reflected upon their own experiences in order to align the corporeal with the psychological and how they approached their surgical transition. A qualitative approach utilising narrative enabled participants to contextualise and relate their experiences and explore their roles in the social world. Narrative inquiry allows freedom of responses and embeds the researcher and participants into the research process which is congruent with the social constructionist framework of this work.

Chapter 3: Ways of knowing

> Reality is constructed through human action and does not exist independently of it; the world, as a meaningful reality, is constructed through human interpretive activity. (Fulton, Madden, & Minichiello, 1996, p. 1349)

3.1 INTRODUCTION

As suggested in previous discussion, SRS remains a controversial treatment option by certain healthcare professionals and yet it is revered as a valid treatment option by others. Nonetheless, SRS has given this previously ignored section of the community some semblance of 'normativity'. Essentially, the controversy associated with altering functioning body parts has raised awareness which has resulted in the trans* phenomenon obtaining notoriety and significance socially, medically, culturally and politically both globally and here in Australia. However, it did this at a cost to the trans* community due to the problematic medicalisation and psychopathologisation of Transsexualism from the middle of the 20th century through to its inclusion into the DSM-III and beyond as a mental disorder. An examination of the literature suggests that the personal identity development of trans* people is something to be socially controlled by the medical profession under the guise of primary care, while in some ways ignoring the complex psychosocial issues associated with undergoing SRS.

The purpose of this research was to understand the meanings that the participants construct in relation to their experiences surrounding the final surgical transition from their biologically assigned gender to their preferred

gender. This chapter discusses and justifies the theoretical framework that was adopted by this research to achieve the aims and objectives previously stated in Section 1.5 of this thesis. These aims are, firstly, to contribute to the body of knowledge of the trans* phenomenon. Secondly, I aimed to understand the psychosocial experiences of trans* and gender diverse people undergoing SRS, and if they perceived their needs were met. Thirdly, I proposed to explore the implications of these findings in relation to the existing guidelines (SOC [Version 7]) (WPATH, 2011a) and finally I aimed to explore the implications of these findings in relation to the Australian legislative framework.

To achieve these aims, the research applied a theoretical lens that drew upon key tenets from the works of such authors as Berger and Luckmann (1966), Ricoeur (1981b, 1984, 1985, 1988, 1991b, 1992) and Merleau-Ponty (2004, 2005). These key tenets embrace the concepts of social constructionism, embodiment and narrative and these are discussed below.

3.2 THE VIEW THROUGH MY THEORETICAL LENS

3.2.1 Social constructionism

The generation of knowledge is a social, cultural and political activity (Willis & Elmer, 2011) where there are multiple realities (Guba & Lincoln, 2004) co-created between the researcher and the individual participants. This particular view of knowledge assumes that truth can never be objective, absolute or singular in character. Knowledge and therefore truth is negotiated through interaction with our social world and recognises that

society is as complex and diverse as its constituent parts (Cohen & Crabtree, 2008).

These multiple realities are dependent upon the social and cultural settings in which they are constructed (Berger & Luckmann, 1966; Guba & Lincoln, 2004; Scott & Marshall, 2009). The important aspect of this construction is that our social world revolves around our daily life, and that everyday life is the "paramount reality" (Berger & Luckmann, 1966, p. 25) which assumes our consciousness resides in the 'here and now'. It is a world that we consciously and constantly modify according to our spatial and temporal location; that is to say we act in relation to our past, present and future.

For Berger and Luckmann (1966, p. 173), personal identity formation is not only a social process dependent upon the social structures that are "maintained, modified, or even reshaped by social relations". There exists a symbiotic and complex relationship between the two forces much the same as the relationship between the butterfly and the flower. It is that personal identity formation through its interaction with those social structures that contributes to the evolution of society, its values and cultural practices. Inherently important in these social interactions, values and cultural practices is language. Berger and Luckmann (1966) argue that language takes its place in our society as the paramount sign system we utilise in our everyday lives.

According to Berger and Luckmann (1966), our identities are formed, maintained and determined by social processes and as individuals interacting in the social world, we use language and our bodies to communicate and

construct those meanings. These constructions are constantly changing and reconstructed with each social interaction (Berger & Luckmann, 1966; Guba & Lincoln, 2004). Furthermore, according to Schutz (1970), the knowledge constructed in everyday life is inherited from historical bases and built upon from the experiences and interactions of others and the social role (identity) that we assume at any given time. Figure 2 clearly illustrates this notion of the 'paramount reality' and the multiple realities contained within it from my own personal journey.

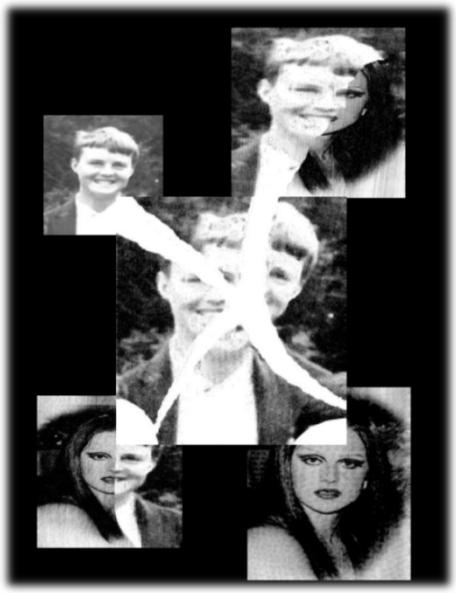

Figure 2. Multiple realities: A researcher's personal journey (Chaplin, 2012).

My daily life constantly evolved (as it still does) as I negotiated my transition both personally and socially. The dreams of a teenage boy were shattered with the realisation that my assigned gender was in question (in retrospect, something I knew from a very young age and in many ways would be considered the classical trans* story) and the only way forward was to realign my corporeal self with my psychological self. But the question

remains...am I the same person in a different body or am I a different person in the same body? Such are my multiple realities as I go about my everyday life.

Why social constructionism?

Those questions equally apply to other trans* people pursuing SRS as they go about their everyday lives. However, processes and outcomes will probably vary significantly. Such is the nature of the multiplicity of human experience and the importance of social constructionism as a mode of knowledge construction in the conduct of this study. This study did not wish to reflect the sameness of the trans* phenomenon; it was concerned with exploring the nuanced differences that exist. Issues associated with trans* identity development are messy and non-linear. Specific features of people transitioning such as age of transition, perceived gender (binary or non-binary), social relationships and the like are unique to individuals in their own social context. Employing social constructionism accounted for that messiness. The multiplicity of reality displayed in *Figure 2* is constructed around a dynamic corporeal embodiment, which occupies a space as one of the central notions of the transitioning body. The notion of embodiment as another component of the theoretical framework is now further explored.

3.2.2 Embodiment

Pivotal to our relationship to the social world is the human body itself (Berger & Luckmann, 1966; Merleau-Ponty, 2005). Merleau-Ponty (2005) argues that the body is more than an object in the world; a vehicle to communicate with the world. He further argues that it is the body that experiences 'being-in-the-world' and is a phenomenon on the margin that

perceives the world around it; that is to say the way we perceive the world is dependent upon the body that is 'with me'. The concept of marginality refers to our inability to view our own body in the normal course of daily living. We can see certain parts of our body generally at any point of time. Other parts of our body can never be in view unless we have a mirror to view them, and even then we can never see it all. We rely on perceptions of our embodiment based upon previously seen and remembered images. As Berger and Luckmann (1966, p. 50) argue, the body (organism) is socially and culturally defined. For these authors, knowledge of the 'self' is reliant on this social context. Similarly to Merleau-Ponty (2005), Berger and Luckmann (1966) state that 'man' is a body (object) and has a body (subject) which experiences the world. Ricoeur (1992, p. 322) sees the body as the mediator between self and the external world. Furthermore, he argues that the 'flesh' is fundamental and makes the world accessible to us. According to Merleau-Ponty (2004), we exist between the psychic and the physiological and awareness is experienced as we attend to everyday life. The importance of this existence is the essence of knowledge itself and "resists the Cartesian mind-body split" (Ellingson, 2008, p. 245).

Why embodiment?

While our bodies are socially, politically and culturally constructed, the theory of embodiment with its notion of the body that is 'with me' is embedded in subjectivities, which as de Beauvoir (1972) suggests is always embodied. It is the physicality of the body and its association to lived experience that can "enable and limit one's behavior and experience" (Schrock, Reid, & Boyd, 2005, p. 319). These perceptions of embodiment

encapsulate the trans* experience. Trans* bodywork modifications traverse a non-linear trajectory; what Ekins and King (1999) categorise as migrating, oscillating, erasing and transcending bodies.[58] The importance of embodiment as a theoretical construct in this study is linked to the embodied subjectivities of the participants as they navigate life towards a distinctively unique corporeal embodiment through SRS. The concept of marginality, which is relevant to memories of former embodiments where there are unruly body parts that are contrary to the psychological knowing, affects every day lived experience. Those everyday embodied experiences, while not typifying cultural mores of what it means to be male/female or masculine/feminine (subjective binary and non-binary gendered perspectives), are demonstrative of the changing realities of the narratives of trans* people as their bodies undergo a dynamic, embodied transfiguration. Indeed, in western culture, gender has traditionally been signified by the body (Mason-Schrock, 1996). A woman born with a penis or a man born with a vagina defies those traditions. The trans* body is in a constant state of flux as the self comes to terms with bodily modifications and what that means. As Ellingson (2006, p. 302) suggests, "theorizing the body must take into account that biology is not fixed or determined." Gendered social issues such as the experience of SRS

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[58] **The migrating body:** Bodily migration considers that trans* people make a direct and permanent relocation (for the most part) across the binary divide through body part substitution (hormonal and/or surgical).
The oscillating body: Bodily oscillation assumes a binary divide similarly to migration. However, it is not a permanent relocation. It encompasses continual reversion between genders through concealing, implying and redefining body parts.
The erasing body: Bodily erasure eliminates the binary gender divide and either involves the systematic removal of masculine or feminine attributes through redefinition and concealment or the systematic removal of body parts enabling the eraser to live in a genderless state.
The transcending body: Bodily transcendence views the binary gender divide as culturally problematic. The transcending trans* person occupies a space outside the dichotomy of male and female as a possible third gender on the continuum where body alterations are optional and pathology does not exist.

require “paying attention to the body, literally and figuratively” (Pillow, 2003a, p. 145) and its “embodied practices” (Pillow, 1997, p. 360). Similarly to the messiness of trans* identity development and the multiplicity of experience embraced by social constructionism, the dynamic nature of embodied knowledge, according to Ellingson (2008, p. 245), “encompasses uncertainty, ambiguity, and messiness in everyday life.” It is the uniqueness of the embodied transformation with its subjectivities that signifies its importance to this work.

Mind and body are neither separate nor mutually exclusive objects. Indeed, the body cannot be viewed merely as an external appendage of the mind, as Descartes’ model of physiology would have us believe (1641/2007). Just as the body has permanence through time, it changes over time and adapts to new experiences through ageing, body modification or illness and so on. The narrative also changes to suit and reflect the social and cultural context in which it is created (Ricoeur, 1991b), and encompasses an identity across the lifespan (Baddeley & Singer, 2007).

3.3 THE METHODOLOGY: A NARRATIVE APPROACH

3.3.1 Situating narrative inquiry

Narrative inquiry was employed as the methodology to underpin this study into the lives of SRS recipients. Historically, narrative inquiry is linked to the philosophical traditions of Heideggerian phenomenology and hermeneutical inquiry (Adams & van Manen, 2008; Josselson, 2006; Liamputtong Rice & Ezzy, 1999; Ricoeur, 1981a, 1981b; Trahar, 2008; Webster & Mertova, 2007). As a research methodology, it is said to have

"reshaped the field of qualitative research, especially with its close attention to experience" (A. McCabe, 2008, p. 541). The philosophical traditions of Heideggerian phenomenology are existentialist in nature, and are concerned with describing and interpreting everyday lived experience (Adams & van Manen, 2008). Phenomenology also recognises the temporal nature of human existence (Kellett, 1997, p. 63), where the significance of lived experience is "relational and directional." That is to say, the importance of experiences are temporally located as past, present and future events that shape/reshape self-interpretation.

As Adams and van Manen (2008) suggest, it is the interpretive focus of the Heideggerian framework that links it with the philosophy of hermeneutics. Historically, hermeneutics is embedded in the interpretation of biblical texts (Skinner, 2008; J. Smith, 2007). Contemporary hermeneutics, in a research sense, is concerned with "the written documents of our culture" (Ricoeur, 1981a, p. 197). According to J. Smith (2007), hermeneutics provides a holistic interpretation by situating the understanding of text (narrative) and recognising the dynamic relationship between the researcher and the participants. As Skinner (2008, p. 386) suggests, the intersubjective nature of narrative inquiry viewed by theorists such as Ricoeur explore how "the author and reader create more empowering interpretations from which to act." The socially constructed nature of the narrative occurs as a result of the relationships between the participants, the researcher, the author and the reader.

3.3.2 What is a narrative?

There is no clear, definitive explanation of what consists as narrative (Riessman & Speedy, 2007). Equally confusing is that "all talk and text is not narrative" (Riessman, 2008, p. 5). Indeed, the journey of the 20th century narrative has embodied an unruly, contradictory and almost anarchical aspect whereby the narrative has developed and evolved using distinct approaches along a continuum (Andrews, Squire, & Tamboukou, 2008; Riessman, 2008; Riessman & Speedy, 2007). In this space, narrative comprises "anything and everything" (Riessman & Speedy, 2007, p. 428). This notion, I would argue, does little more than create a narrative vacuum, and thus the narrative implodes into nothingness. It is rightly argued by Riessman and Speedy (2007) that narratives of this nature are merely popular discourses created to expound contrived notions and concepts.

At its most constrained point on that continuum, narrative can be traced back to the Greek civilisation. From an historical perspective, the narrative had its beginnings in Ancient Greece, where the renowned philosopher, Aristotle, interrogated the Greek tragedy (Riessman, 2008). Each tragedy followed a classic story format with a beginning, middle and an end. The content of the tragic literary narrative drew the audience in with its twists and turns (the plot) and its attempts to answer moral dilemmas of the era. Its theoretical underpinnings were derived from its highly structured approach to sociolinguistics in much the same way as Labov and Waletzky (1967)

deconstructed text and events into basic, predetermined narrative units[59] (Andrews et al., 2008).

These narrative units also followed a highly structured model where each unit was drawn from the written text or the spoken word. The purpose of this type of narrative was to develop theoretical understandings of language (Riessman, 2008). However useful this type of interrogation may be in literary circles, the point of my argument is that it fails to recognise the contextual nature of social interactions, the complexity of the human condition with all its nuances of identity and the manner in which language is grounded in our everyday lives, tied to our socialisation and institutions.

In contrast, the opposite end of the narrative continuum displays a dynamic embodiment that can be captured using language as its social medium. This aspect implies the notion that narrative dialogue is a combination of past, present and future that has a unifying power for human existence and is a vehicle that we use daily to develop self-knowledge and the world around us (Rankin, 2002). Ricoeur's (1991b) philosophy conceptualises this hermeneutic approach through the use of the narrative which he argues is the key to our personal durability as we gain an understanding of our own identity through time in our everyday world. The phenomenon that is life can be equated to the stories we tell about it

[59] The six part model breaks textual clauses into its distinct elements.

- Abstract – a statement that sets the scene of the narrative
- Orientation – defines time, place and events
- Complicating action – the main body of the story
- Evaluation – interpretation of significance of events
- Resolution – the final outcome
- Coda (often missing) – relocates the players [narrator and listener] (Grbich, 2007).

(Ricoeur, 1991b). For Ricoeur (1981a, 1981b), emplotment and temporality are the key concepts that consolidate a story.

3.3.3 Emplotment and temporality

Ricoeur (1981b, p. 167) defines the plot as "the intelligible whole that governs a succession of events in any story," or "a synthesis of heterogeneous elements" (Ricoeur, 1991a). Furthermore, Ricoeur (1981a) explains that narratives are both chronological (episodic) and configurational (constructional). According to Mishler (1995), the former relates to the sequence of real-time events, whereas the latter is concerned with the narrator's representation or construction of those events. The importance of this distinction is a fundamental component to understanding how we construct meaning (Hardy, Gregory, & Ramjeet, 2009); although events occur in a physical order, how we reconstruct or plot those events during the storytelling process may take a very different shape (Ricoeur, 1981a).

Temporality assumes that the narrative is based in real time (Mishler, 1995) and constructed contextually according to the importance of the narrative at any given point in time. Ricoeur (1981b, p. 169) recognises the kairotic nature of timing; "there is a time to do this, a right time and a wrong time", and its relationship to the narrative. As storytellers, human beings will tell stories that are contextually important at a particular point in time. This moment in time is the 'kairos'. It is our human preoccupation to say or do the right thing as the opportunity arises in our everyday life.

The narrator's reconstruction of their narrative reinforces the temporal nature of the narrative as the story will link the past, present and future (Gerrish & Lacey, 2010); that is to say, the narrator recounts an event that

has significance to their existence in the present and searches for meaning in relation to preceding events (causation), and then looks for ways to project that event into the future. It is the combination of these attributes that gives the narrative its coherence through self-inquiry and ascribes the meaning derived through self-reflection.

The outcome of events is determined by the narrator's representation of their own realities as they attempt to make meaning of those events at that point in time. The methodology recognises the integral relationship between the researcher and the narrators as a unique social relationship is formed between the two, thereby encapsulating the co-constructed nature of the narrative. Narrative inquiry proposes to explain how we make sense of our world and our traditions and assumes that knowledge is socially constructed (Sparrowe, 2005). Furthermore, storytelling gives the individual the opportunity to reflect on experiences and to construct a coherent biography in the formation of their identity (Berger & Luckmann, 1966, p. 64), and this identity is a social construction that is continually being modified (Berger & Luckmann, 1966, p. 173).

Why narrative?

Narrative can be defined as "discourse, or an example of it, designed to represent a connected succession of happenings" (Webster's Collegiate Dictionary, 1947, p. 622). In the context of this study, the narrative is constituted around the phenomenon of SRS, and as a narrative inquirer, my interest is in 'experience.' The "connected succession of happenings" refers here not to the stories told but to the "culturally meaningful and recognizable boundaries…that give a stretch of talk or text a unity and coherence"

(Mishler, 1995, p. 91). My interest is in "stories lived and told" (Clandinin & Connelly, 2000, p. 20). This exploration into SRS as an experience relates to my position as I occupy a space of both insider and outsider in this research (see Section 4.9.3). SRS is therefore, from my research and personal perspective, culturally meaningful. As A. McCabe (2008) notes, narrative as a methodology is somewhat autobiographical in nature and, as a researcher, reflexivity and reflective practice are integral to the research process.

Traditionally, narrative was classified as "homogenizing and essentializing" (A. McCabe, 2008, p. 541). However, the significance of employing narrative in this study is related to the diverse experiences and situations of the participants. In that respect, "selves and experiences differ in relation to historical, cultural and practical contexts" (Crossley, 2000, p. 529). These circumstances result in an interesting interplay/relationship between the participants and the researcher. We both become embedded in the research process in the reliving/retelling of storied lives. As stated by Clandinin and Connelly (2000, pp. 63-64), "[a]s researchers, we come to each new inquiry field living our stories. Our participants also enter the inquiry field in the midst of living their stories." Thus, employing narrative becomes a holistic way of understanding experience.

Alongside the significance of the relationships in this context are the subjective lived experiences of the participants. Individuals diagnosed with Transsexualism, GID or GD have often been marginalised (Dean et al., 2000; R. Turner, 1999) because of their assumed psychiatric condition. As suggested by Liamputtong (2009), narrative gives marginalised individuals such as trans* people the opportunity to talk openly about a life changing

event. The storytelling aspect of the methodology also ties personal experiences to historical circumstances which yields psychosocial perspectives of the participants that this research aims to explore and understand.

3.4 SUMMARY

This chapter described and justified my approach to the theoretical framework and the methodology of this research. The theoretical framework and methodology that informed this study are constructed around the concept of self, where "an understanding of the 'self' as a phenomenon [is] characterized by interpretation, variability, relativity, flux and difference" (Crossley, 2000, p. 529). These characterisations are inherently linked to social constructionism, embodiment and narrative as people experience the world in different ways in bodies that are unique to them. Language as a social medium[60] is employed to communicate thoughts, ideas and emotions. The language of the body experiences the world (Merleau-Ponty, 2012), thus "language constitutes reality" (Kvale, 1992, p. 35) and our understanding of the world around us (Maggs-Rapport, 2001). As Merleau-Ponty (2012, p. 203) suggests, "the body must become the thought or the intention that it signifies to us." Finally, as put by Mason-Schrock (1996), the construction of new narratives through a radical shift in corporeal identity, through SRS in this case, is both subjective and interactive and the processes involved are

[60] As stated by Gergen and Gergen (1983, p. 272), "[t]he self narrative need not be a verbal construction. Although verbalization may be common, a sense of narrative may be embedded in a more basic experience of fittingness or directionality among events."

shaped by past events; thereby new gendered realities form the narrative reconstruction.

The key assumptions of social constructionism employed in this research 'fit' the way in which trans* people go about their everyday lives. The multiplicity of lived experience creates different realities. As suggested by Polkinghorne (1992, p. 149), the nature of reality implies a "process of continuous change." It is self-evident that there is a strong association between postoperative trans* people and their bodies as they are experienced (as they pursue to align their physical and psychological worlds through SRS). Furthermore, narrative inquiry is strongly linked to the social constructionist framework adopted by this study because of the intersubjective nature of the inquiry and the social relationships formed between the researcher and the narrators (Clandinin & Connelly, 2000).

In the chapter that follows, I turn to the methods employed in the conduct of this research. The purpose of that chapter is to describe in detail and justify 'ways of doing' the present study and to provide methodological transparency, which enhances the rigour of the project. The key discussion points are constructed around the issues of sampling and the selection criteria, accessing and recruiting participants, demographic details of the participants and how material for this study was generated and analysed. Additionally, ethical considerations and the robustness of the study are discussed.

Chapter 4: Ways of doing

> The bottom line is that the method of research should match the question being asked. Qualitative research methods are best suited to questions about processes, experiences, meanings, and complex interactions and behaviors. [sic] (Rich & Grey, 2003, p. 958)

4.1 INTRODUCTION: THEORY INFORMING METHOD

In the previous chapter, 'ways of knowing' were discussed and justified in relation to the psychosocial needs of trans* and gender diverse people who undergo SRS. I justified the theoretical framework based upon some key assumptions underlying the theories of social constructionism, embodiment and narrative. The point of that argument was to demonstrate that these theoretical assumptions have special significance to trans* people as they traverse the irreversible process of gender reassignment. The need to realign the physical body with the emotional and psychological body through surgical intervention in itself creates multiple realities. The purpose of this chapter is to describe in detail and justify 'ways of doing' the study and to provide methodological transparency, which enhances the rigour of the project. The key discussion points are constructed around the issues of sampling and the selection criteria, accessing and recruiting participants, demographic details of the participants and how material for this study was generated and analysed. Additionally, ethical considerations and the robustness of the study are discussed.

If we consider the words of Rich and Grey (2003) above in light of the research question,[61] there needs to be an epistemological 'fit' with what the question asks, the theory that is informed by that question, and the ways in which the theory informs the methodology and the methods employed to carry out the research. As stated by Popkewitz (1998, p. 141), "[d]ata collection and theory are bound." The theoretical framework reflected in this study based upon the assumptions of multiple realities, uniqueness, perceptions of everyday embodied experience, creating meaning through social interaction, lived and told stories is relevant to a narrative approach with its lived experience of people and its embeddedness into everyday life, as previously argued. As put by Bach (2007, p. 282), individual experiences are unique with a "different 'angle of vision' that touches on a common world." Narratively speaking, those experiences are lived and told in a variety of ways. The focus of this study is the experience of SRS, and to 'fit' what the research question asks, data generation through the creation of visual imagery and the art of conversation which lived and told the story' reflect the participants' views of that experience.

Visuality refers to "how we see, how we are able, allowed, or made to see, and how we see this seeing and the unseeing therein…" (Foster, 1988, p. ix). Photographs, as one example, offer a myriad of possibilities by recording actual events in a single, arbitrary moment of time; a time that is gone and can never be replaced. For Prosser (2005, p. 1), "they show the

[61] To remind the reader, the research question in this study was: "How do trans* and gender diverse people who have undergone sex reassignment surgery (SRS) perceive their psychosocial experiences of the surgical transformation?"

irreversible passing of time." According to Prosser (2005), not only are we recounting a lost period of time, but the photograph represents a mirror of our realities. Similarly, drawings can represent a moment or moments in time and equally be a mirror of the multiplicity of reality. "Visual imagery is never innocent; it is always constructed through various practices, technologies and knowledges" (G. Rose, 2007, p. 26). This notion becomes evident as one considers art throughout history; one can see the use of imagery is socially, historically and culturally bound. More importantly, drawings can create a perception of a time gone by when one is asked to reflect and draw a moment or moments in time. As Weber and Mitchell (1995, p. 19) argue:

> Because a picture can communicate simultaneously on many levels, drawings are useful not only as iconic images, but also as layered painting that hide or combine other social, cultural, and personal images…drawings can thus reveal aspects of our personal and social knowledge – how we see the world, how we feel, and what we can imagine…"

Thus, visual imagery was employed to unravel thoughts and emotions concerned with stories of the transitioning body that were culturally meaningful to the trans* men and women in this study. As de Mello (2007, p. 209) suggests, this approach positioned the participants as constructing their own narratives "from their own perspectives." The social processes initiated through the creation of those images elicited conversations (unstructured interviews), an essential tool in the construction of narratives (Liamputtong, 2009). The stories created through such conversations "allows a researcher to examine how various relationships, events, and memories are created and told in different social contexts and in distinctive relationships" (A. Rogers, 2007, p. 105). In turn, these explorations give rise to what Pinnegar and

Daynes (2007, p. 25) refer to as “blurring knowing” of human experience, with its “tentative and variable nature.” This blurred knowing celebrates the nuances of the theoretical framework where “the stories we tell are not necessarily those lives as they were lived, but those stories become our experience of those lives” (Frank, 1995, p. 22).

4.2 SAMPLING: A PURPOSIVE APPROACH

This narrative project sought, in part, to gain an understanding of the lived experiences of trans* people who had undergone SRS and how they navigated that life changing event. According to Morse (1991, p. 127), selecting a sample in qualitative research will ultimately affect the quality of the analysis and outcomes of the research. Drawing on the question posed by Popay, Rogers and Williams (1999, p. 346), “does the sample produce the type of knowledge necessary to understand the structures and processes within which the individuals or situations are located?”

For this reason, a purposive sample was obtained whereby the fourteen participants were recruited on the basis of their extensive personal knowledge of the phenomenon and therefore were able to provide the richest descriptions based upon a wide range of experiences, a necessary component of qualitative inquiry (Curtis, Gesler, Smith, & Washburn, 2000; Morse, 1991; Polit & Beck, 2006). A purposive sample which produces knowledge as questioned by L. Rogers (1999) contributes to the believability and reliability of the participants’ descriptions of their experiences (Curtis et al., 2000; L. Rogers, 1999).

4.3 THE SELECTION CRITERIA

In line with the purposive sample to be recruited, it was necessary to formulate selection criteria that were ethical, legal, succinct and that maximised the opportunity for appropriate participants to be recruited to the study. Therefore, participants were selected using the following selection criteria.

Participants for this study must:

- Be over 18 years of age[62]
- Have undergone SRS at least six (6) months previously[63]
- Be fluent in English,[64] and
- Be able to give informed consent[65]

4.4 PARTICIPANT ACCESS AND RECRUITMENT

Trans* and gender diverse people belong to a minority group, comprising 1.4% of the global population on estimates by the UK Equality and Human Rights Commission (2012). As a group, trans* people are traditionally marginalised, stigmatised and socially excluded from mainstream society based upon their diversity or perceived deviance from societal norms (Dean et al., 2000). Gaining access to such marginalised people can be

[62] Drawing on WPATH (2011a), SRS should only be performed on those people that have acquired the legal age of majority in their own country.
[63] As previously defined, SRS for the purposes of this study encompassed any of the irreversible surgeries carried out on the primary or secondary sexual characteristics of trans* people. A period of six months minimum following surgery allowed an adequate recovery period.
[64].This aspect allowed ease of understanding for transcription and interpretation purposes and was an ethical requirement of the QUT HREC.
[65] This was an ethical requirement in consideration of a previous diagnosis of GID or GD.

complicated as Noy (2008) explained for a study he conducted when attempting to access marginalised Palestinian and Jewish men in Jerusalem. From a personal perspective, it goes beyond social marginalisation; with trans* people there also exists a personal marginalisation anecdotally known as 'living in stealth' and I was one such trans* person who lived like this for over 25 years following my SRS in 1983.

Outing one's self was only done on a need to know basis, for example with intimate partners, doctors, employers and so forth. To the person on the street, a trans* person living in stealth is no different to any other cisgender person. This invisibility was/is intended to ensure acceptance by society and therefore one was no longer marginalised, stigmatised or socially excluded. Many trans* people openly choose to live this heteronormative[66] and socially invisible existence; a form of personal erasure (Namaste, 2000), if you like. The point is that gaining access to participants for this study relied upon the resources of trans* community, peer support and health organisations and it is for this reason that a nonprobability sample employing convenience and snowball sampling techniques were used to recruit participants for this project.

Community organisations such as the above are well received by the trans* and gender diverse community and I was able to gain access to participants through their networking capabilities. They provide a platform for the socially invisible to interact with peers and obtain support in times of need in a safe environment. In Browne's (2005) view, social networking provides

[66] Heteronormativity is defined as "socio-legal, cultural, organisational and interpersonal 'practices that derive from and reinforce a set of taken-for-granted presumptions relating to sex and gender'" (Mander & Page, 2012, p. 10).

an avenue to recruit participants that may be described as hard to find or hidden and it was a technique that Browne (2005) successfully applied to recruit participants for her doctoral study on non-heterosexual women from within her own social network. Other studies (Boyle et al., 1997; Martin & Dean, 1993) investigating 'elusive' and 'deviant' populations applied this common technique for locating and recruiting participants. Boyle et al. (1997) used snowball sampling to recruit 230 sex workers in Queensland in a study on psychological distress. Similarly, Martin and Dean (1993) recruited 746 gay men for an epidemiological study on AIDS in the USA using this technique.

I joined one such social networking group in Brisbane called MGOV to build rapport with local trans* and gender diverse people and to gauge their willingness to support me in this project. I attended many of their regular monthly meetings and obtained feedback from them on the research, including the ethics components and these particular aspects will be discussed later on in this chapter.

Overall, I made contact with 15 trans* support and health organisations in Queensland, New South Wales, Victoria, South Australia, Western Australia, Tasmania and the Australian Capital Territory. They comprised community and peer support organisations, social networking organisations and health support agencies (Appendix E). With the exception of MGOV, who operate a 'closed group'[67] Facebook page, I introduced myself and details of the project in an introductory email (Appendix G), a recruitment email (Appendix H) and a recruitment flyer (Appendix I) for those

[67] In a 'closed group' Facebook page, only members can view posts made on the page.

organisations to forward to prospective participants if they chose to help me. I uploaded a copy of the recruitment email and the information sheet onto the MGOV 'closed group' Facebook page for members to view and disseminate to their networks. It is unknown how many of those organisations disseminated the information on my behalf as not all of them made further contact with me. Perhaps, their lack of contact relates to another form of stealth by remaining invisible as an organisation from me, as the researcher.

4.5 THE PARTICIPANTS

4.5.1 From prospective to actual participant

Twenty five prospective participants contacted the researcher in reply to the advertisements through the various organisations. When a prospective participant made contact, I arranged to send a more detailed information sheet (Appendix J) and consent form (Appendix K) should they decide to participate. They were encouraged to contact the research team if they had any queries regarding the project and they were also encouraged to forward information on the project to any other potential participants in their social network. This snowballing technique of recruiting participants is a legitimate (Boyle et al., 1997; Browne, 2005; Martin & Dean, 1993) and often necessary option for populations that are marginalised (Dean et al., 2000), difficult to locate (Dunne, 2002; Holloway & Freshwater, 2007; B. Whitley, 2002) or referred to as social or sexual deviants (Lee & Renzetti, 1990).

Of those 25, seven did not respond to any further communication. One trans* man did not meet the selection criteria of having undergone SRS at least six months previously. Another prospective participant (trans* woman)

advised me that she was having mental health issues at the time. As a result, I did not want to cause her further distress and did not pursue recruiting or interviewing her for ethical reasons. She later contacted me to inquire if I was still seeking volunteers when her health issues had resolved. By this time, I had already ceased data generation and I advised her accordingly.

A further two prospective participants (one trans* man and one trans* woman) who contacted the researcher resided in Western Australia. Unfortunately, I could not justify the cost of a 7200 kilometre round air trip to conduct two interviews as my budget did not allow it and as discussed time constraints were against me. I considered whether there were other options such as a telephone link up via Skype, but in order to do that would have meant another variation to my ethics application. Consequently, I advised those two particular people that I was unable to interview them.

In all, this study recruited fourteen participants (trans* men [n=9] and trans* women [n=5]). Of the nine trans* men, eight participants identified as male and one participant identified as trans* male. Four of the nine trans* men identified as Australian, two participants as Dutch/Australian, one trans* man as Anglo/Australian, one as Indian/Australian and one participant identified himself as Australian of European descent. All of the participants in this group had undergone at least one chest surgery (four participants had a revision to the original surgery). Three participants had undergone a full abdominal hysterectomy. The total number of years since their first surgery ranged from 1-14 years with an average of 5.2 years.

Their ages ranged from 25-48 years with an average age of 32.2 years. All the trans* men were employed either in paid employment (n=8) or self-employed (n=1) and had completed secondary or tertiary education (n=1 and n=8 respectively). Two men from this group lived alone, three lived with their spouse or partner and four lived with others such as friends or with parents. Five of the trans* men were single and four were in de facto relationships.

For the five trans* women, four participants identified as female and one participant identified as a trans* woman. Two participants described themselves as Australian, one participant identified herself as English/Australian; another identified as an Irish/Russian/Australian and the fifth trans* woman identified herself from an English/Irish/Scottish/North American Indian background. All five trans* women had undergone a vaginoplasty. The total number of years lapsed since that surgery ranged from <I-12 years with an average of 7 years.

For the trans* women, their ages ranged from 42-78 years with an average of 52.6 years. Two of the trans* women were in paid employment and three received government assistance (disability support pensions [n=2] and old age pension [n=1]) and had completed secondary (n=2) or tertiary (n=3) education. Of this group of trans* women, three lived alone, one lived with her spouse or partner and one was living with others (friends). Of these five trans* women, two were single, one was married, one was widowed and one was divorced. A summary of the entire cohort is presented in Table 3.

Table 3

Demographic Profiles of the Participants: N=14

Attribute	Description	Number
Gender (self-defined)	Male	8
	Trans* male	1
	Female	4
	Trans* woman	1
Age ranges	21-30	3
	31-40	5
	41-50	5
	>50	1
Living arrangements	Alone	5
	With spouse/partner	4
	With others	5
	Other (e.g. homeless)	0
Place of residence	Queensland	7
	New South Wales	4
	Victoria	3
Type of surgery (SRS)	Chest	9
	Chest revisions	4
	Hysterectomy	3
	Vaginoplasty	5
Marital status	Married	1
	Divorced/separated	1
	Widowed	1
	Single	7
	De facto	4
Highest education achieved	Year 12/HSC[a]	3
	Diploma	3
	Graduate Diploma	1
	Bachelor Degree	5
	Masters Degree	2
Employment status	Paid employment	9
	Self-employed	2
	Unemployed	0
	Retired	1
	Other (e.g. student)	3[b]
Years since surgery	<1	1
	1-7	8
	8-14	5
Ethnicity/nationality (self-defined)	Australian	6
	Dutch/Australian	2
	Indian/Australian	1
	Anglo/Australian	1
	English/Australian	1
	European/Australian	1
	Irish/Russian/Australian	1
	English/Irish/Scottish/Nth American Indian	1

[a]Year 12 and Higher School Certificate (HSC) are equivalent educational attainments.
[b]One participant described himself as being in both paid employment and a student.

4.5.2 Sample size: theory versus practice

A major consideration in any qualitative research is achieving an adequate sample size to generate findings that may be applied to comparable populations (Horsburgh, 2003) as opposed to quantitative studies which rely on statistical power to generalise to entire populations (Polit & Beck, 2006). According to Guest, Bunce, and Johnson (2006), there are varying viewpoints on how many participants are indeed needed in qualitative research. Guest et al. (2006) cited many examples of studies which all conveyed varying adequate numbers of participants with seemingly little agreement. For example, "at least six…approximately thirty-fifty...between five and twenty five…twenty-thirty" (Guest et al., 2006, p. 61).

Concepts such as data saturation (Charmaz, 2006) and theoretical sufficiency (Dey, 1999) to determine sample size are often used. Both of these methods to determine sample size are extremely arbitrary and rely on the researcher making a judgement call based upon personal analytical opinion. Nonetheless, authors such as Liamputtong (2009) suggest that the depth and detail of interview material generated narratively dictates a small sample size. Pursuing this further and drawing on the work of Blumer (1979, p. 156); "a half dozen individuals with such knowledge constitute a far better "representative sample" than a thousand individuals who may be involved in the action that is being formed but who are not knowledgeable about that formation."

In an attempt to determine when enough interviews is enough, Guest et al. (2006, p. 66) conducted in-depth interviews with 60 women from Ghana and Nigeria (30 from each country) and found that after twelve interviews,

they had achieved “92% of all codes applied to the Ghana data.” Furthermore, some codes developed following that initial twelve interviews were variations of themes already existing in the data. However, the authors (Guest et al., 2006) noted that their results, although evidence-based, may not be generalisable to all qualitative studies due to a variety of factors including the experience of the researcher/s and the manner in which the coding of the data is performed.

Turning now to the practicalities of conducting this research and the need to finalise interviews due to time constraints imposed by funding and candidature issues, it became apparent that these two issues and the need to begin the analytical process would dictate the sample size generated in this study. Locating prospective participants was a slow, at times soul destroying process from the beginning. From my first advertisement for participants through MGOV on their ‘closed group’ Facebook page, only two interviews were conducted locally in the two months following the start of data generation, which was less than I anticipated.

Two more months elapsed before I interviewed the next three participants, all of whom were in New South Wales. This was followed by a break of two months before interviewing one more Brisbane participant. A three week break ensued and an interview in Northern Queensland was conducted. That made a total of seven interviews in five months. This was half the total number I proposed interviewing originally. In my original research proposal, I nominated up to fifteen interviews. Almost another two months elapsed; I interviewed six participants in ten days. Four of those interviews were grouped together as they were interstate (New South Wales

and Victoria). By this time, it was the end of October 2013, and I had one more local interview in the pipeline for the beginning of December. It was at this time I found it necessary to literally draw a line in the sand and cease data generation. Drawing on Guest et al. (2006, p. 61), "waiting to reach saturation in the field is generally not an option."

4.5.3 Arranging the interviews

The face-to-face interviews for this project were conducted in Victoria, New South Wales and Queensland (the participants' states of residence) and involved the researcher travelling great distances in order to generate data for the project. This logistical issue necessitated grouping interviews together where possible over several days in the field. This was not an issue for the majority of the Queensland based interviews as six of the seven interviews were based in Brisbane and environs. For the Victorian, Northern Queensland and New South Wales interviews, it was necessary to wait until I had sufficient interviews to conduct at one time or I was in those locations on other personal business.

This approach meant that I needed to keep in regular contact with those people who had agreed to participate until final arrangements could be made to set a meeting date. This regular contact was an integral part of the rapport building process with these particular participants and assisted in creating meaningful social interactions and a sense of comfort and safety, which according to Renzetti and Lee (1993), is an essential component of establishing trust for the reason that developing that interpersonal relationship removes that objective, indifferent and disinterested researcher.

4.5.4 The interview sites

The interviews were either conducted in a private office at QUT Kelvin Grove Campus (n=4) or other agreed public location such as a library, public meeting room (n=7) or public park (n=3). Conducting the interviews in these types of locations ensured that the safety of both the researcher and the participant could be maintained. Marginalised individuals such as trans* and gay people need to feel safe in an interview situation (Kong, Mahoney, & Plummer, 2001). The chosen sites were mutually agreeable to both parties. I was guided by the views of the participant to the suitability of the location, more so with those interviews outside of Brisbane for the reason that I was not as familiar with some of the locations. This approach provided another avenue to form and strengthen interpersonal relationships with the participants and thereby give them a sense of control and ownership in the process. By nullifying that perceived power relationship between the 'researcher' and the 'researched' (Mishler, 1986), it was envisaged that this approach would assist in being more sensitive to the needs of the participants and demonstrate my flexibility (Morse, Barrett, Mayan, Olsin, & Spiers, 2002).

4.5.5 The lead up to the interviews

Each participant was met at the prearranged venue suitable to both parties. This provided an opportunity to literally put a face to the name for those participants I did not already know personally (see Section 4.8.4). Prior to the interview, a further component of the rapport building process was telling my own trans* story. This disclosure displayed my honesty and willingness to share personal information with the participants which led to an

increase in the rapport. Therefore, I was able to generate and secure the interpersonal relationships so necessary in this narrative research (Lee & Renzetti, 1990; Renzetti & Lee, 1993; Warren, 2001). The trust I formed was founded in my self-disclosure of my views, emotions and reflections of my own life and the concept of "strict reciprocity" (J. Johnson, 2001, p. 109) which is only possible when the researcher belongs to the population under investigation.

Additionally, during this phase, the participants were guided through the participant information sheet (Appendix J) and had the opportunity to get clarification on all aspects of the research. All queries were answered to the participants' satisfaction before signing of the informed consent document (Appendix K) took place if they had not already returned them to me via email. Following this process and prior to the formal beginning of the interview, each participant provided demographic information. The tool I employed to gather this information is located at Appendix L.

4.6 DATA GENERATION

There are many methods of data collection available to the narrative researcher (Andrews et al., 2008). These methods include field observations, interviews, historical text and visual sources (Andrews et al., 2008; Gerrish & Lacey, 2010). The data for this project were generated using both innovative (participant produced drawings) (Bentley, 2010) and traditional (unstructured interviews) (Liamputtong, 2009; Mishler, 1986) qualitative methods.

4.6.1 Participant produced drawings

> Drawings offer a different kind of glimpse into human sense-making than written or spoken texts do, because they can express that which is not easily put into words: the ineffable, the elusive, the not-yet-thought-through, the sub-conscious. (Weber & Mitchell, 1995, p. 34)

According to Weber (2008), interest in using visual imagery (paintings, photographs, sculptures and collage to name a few) in qualitative research increased in popularity in the latter half of the 20th century. More specifically, in health related research, visual images have been used successfully in both phenomenological and narrative research both as a data source and a method of collection (Bergum & Godkin, 2008). Kearney and Hyle (2004) used drawings created by the participants as an introductory data collection method in their research on the emotional impact of organisational change.

The authors (Kearney & Hyle, 2004) argued that although drawings are not commonplace in research, drawings allowed the participants to explore emotional issues they may not otherwise explore. Additionally, the drawing activity was seen as an advantageous introduction to the interview to follow as it provided the participants with a personal framework to capture their own experiences. According to Kearney and Hyle (2004), it was this freedom of expression in the initial phase of the interview that contributed to reducing researcher biases because the researcher imposed no boundaries on the activity nor stayed in proximity to the participants while they were completing the activity.

In a study on the use of psychiatric medications (Bentley, 2010), participants were asked to create a colour drawing of their experiences of taking such medications. According to Bentley (2010), an art therapist

attested to the therapeutic nature of the process for the participants. Additionally, the visual representations brought to life the experiences of the participants and overlapped with the themes constructed from the analysis of the interviews, which aligns with the findings of Kearney and Hyle (2004).

As this research was essentially about the final surgical transition (change) of trans* people, the use of participant produced drawings was a useful and suitable method of data generation for this study. This method allowed freedom of expression (Kearney & Hyle, 2004) and represented one form of reality yet at the same time represented multiple viewpoints (Weber, 2008), which converges with the social constructionist framework of this study. According to Weber (2008), from a theoretical perspective, a visual image can stimulate the use of embodied knowledge because it goes to the heart of how a particular experience makes you think and feel.

Furthermore, according to Kearney and Hyle (2004) and Weber (2008), this method may contribute to greater rigour of the research by allowing greater transparency and facilitating reflexivity in the research design. Therefore, each participant was asked to create a picture or pictures which represented their experiences of the final transition to their preferred gender by SRS. These pictures guided the format of the interview to follow. However, it should be noted that there was no compulsion to complete this activity and, equally important, no judgment of their artistic ability if they chose to do the drawing activity. Of the 14 participants, 12 agreed to complete this component of the interview. The other two participants who declined to complete this activity expressed the views that they were either happy to express themselves verbally or that they were not a visual person.

Although, one of these participants said that she would complete it if I required her to do so. I indicated that the activity was voluntary and that if she did not wish to complete it, there was no compulsion to do so.

4.6.2 The unstructured interview

Unstructured, audio recorded interviews were conducted at mutually suitable locations. The unstructured interview is traditionally seen as the major method of data generation in narrative research (Liamputtong, 2009; Mishler, 1986) and is consistent with the methodology. At the outset, the participants were asked to explain the significance of the drawings if they created one in the initial phase.

These explanations focused the format of the interview and provided a succinct experiential representation (Kearney & Hyle, 2004) and allowed the researcher to guide the story prompted from the participants' stories of the drawings in a conversational manner for the most part. This approach is intrinsically linked to both the methodology and the theoretical framework. The conversation empowered the narrator to take control of the reliving of their own experiences. The narrative was developed and plotted as the narrator recounted their daily life experiences at that particular point in time; selectively imparting knowledge on what was important to them. Turning now to the format of the interview, there were two possible scripted scenarios used during the interview phase and these are described below.

4.6.3 The interview format

The digitally audio recorded interview was divided into two parts. At the beginning of each interview, each participant was invited to complete a voluntary drawing activity which would be a picture or series of pictures that

symbolised their experience of undergoing SRS. The participants were advised that the researcher would not judge their artistic ability, but that it was an activity designed to facilitate their thought processes on what was important to them about their personal transition. Each of the 12 participants[68] was set up with an A3 sketch pad and a complete set of 18 coloured fine point permanent markers and they were asked to think about the final transition from their assigned gender to their preferred gender. They were asked to draw one or more pictures that describe how they experienced "the change"[69] to their preferred gender. Following this activity, each of these 12 participants was asked to explain the significance of the drawing/s they created, give the drawing a title and a few words to describe the drawing – a mode of self-interpretation. The two participants who did not complete the drawing activity were asked to reflect on how they experienced "the change" verbally. Both of these activities prompted questions for the interviews that followed. A detailed description of the interview format and a list of possible questions are reproduced at Appendix D.

4.6.4 Finalising the interview

At the end of each interview, I asked each participant how they were feeling, whether they are happy with the descriptions of their experiences, and whether they would like to add anything further. I ensured each participant had retained the list of trans* support organisations (Appendix M) and the participant information sheet (Appendix J). Additionally, permission

[68] It is an opportune time to remind any reader that in the interests of participant confidentiality and anonymity, all identifying features of the participants such as names, places, writing styles have been removed from the images.
[69] "The change" is a colloquial term used by transsexuals.

was sought to follow up with the participants following the interview to clarify/expand/focus upon the responses given to aid the analysis process.

4.7 DATA ANALYSIS AND THE ANALYTICAL FRAMEWORK

In the context of the current study, it was necessary to develop an analytical approach which could be used to analyse data from two distinct methods of data generation; being participant produced visual images, and in-depth interviews. It also necessitated adopting an approach suitable to a social constructionist perspective. Gubrium and Holstein's (2009) notion of 'narrative borders' satisfies those requirements, and these are discussed below.

4.7.1 Narrative borders: a structural explanation

The structural framework for this analysis was designed using Gubrium and Holstein's (2009, p. 225) notion of 'narrative borders' which explained the three essential components of a narrative. Firstly, the narrative account (story) needs to relate to a "discernible topic". Consequently, this research was guided by the research question which defined that topic. The current study asked:

"How do trans*people who have undergone sex reassignment surgery (SRS) perceive their psychosocial experiences of the surgical transformation?"

This "object of inquiry" (Gubrium & Holstein, 2009, p. 25), SRS and its perceived meanings to the participants provided the focus of data generation and grounded the analysis. Other potential topics emerged throughout the

data generation process based upon the participants' accounts, but central to this investigation were the stories related to SRS. The second essential component of a narrative is the formation of the plot, where "the topic develops in a particular way as a story unfolds" (Gubrium & Holstein, 2009, p. 225), and the plot links events that give structure to the whole (Ricoeur, 1981a; H. White, 1981). Inextricably linked to the formation of the plot is the notion of time as the story unfolds; linking the past, present and future to make sense of personal identity (Ricoeur, 1991b). Traditionally, a plot is composed of three dimensions; a beginning, and middle and an end (Gubrium & Holstein, 2009). In this study, each participant contributed to the plot by providing their individual narratives which were co-constructed during the interview process. The totality of the narratives elicited the third 'narrative border,' the development of themes (Gubrium & Holstein, 2009, p. 226), which I refer to as narrative concepts.

In the first instance, these borders appear to be simplistic representations of a narrative approach. However, exploration of these particular aspects of the narrative indicates that these borders apply not merely methodologically but also epistemologically. To illustrate this aspect, let us reconsider the notion of 'narrative borders' in relation to my epistemological foundations. Contextually, the theoretical framework of this research was designed around several central principles of social constructionism, embodiment and narrative ('narrative border' #1, the discernible topic). To remind the reader, in keeping with Berger and Luckmann (1966), this work is based upon the assumption that knowledge is socially constructed where multiple realities exist. What applies to me is my

reality. There may be shared aspects of that reality with people in my social network; after all, we are social animals interacting and sharing knowledge as we go about our everyday lives. It is through interacting in these social situations we are constantly adapting, modifying and changing our views of the world. However, my reality can never inhabit exactly the same temporal and spatial location as the next person for the reason that how I perceive the world comes from a differently embodied social, cultural and political perspective. Metaphorically speaking, knowledge can be viewed as a jigsaw puzzle, where individual pieces are joined together and each is linked and reliant upon the next to form the whole ('narrative border' #2, the plot).

Central to that knowledge construction is the body and its relationship to the world. We use our bodies to communicate with the world and we experience the world through that body. This aspect of embodiment implies that the body being in the world is, in itself, a social process – our bodies are socially and culturally defined. It is the body, or as Ricoeur (1992) would have it, the "fundamental flesh", that makes the world accessible to us. Beyond the physicality of the body as a mode of communication, we use language as a social medium in combination with that body to communicate with the social world. For Ricoeur (1991b), language is a key component in our personal durability as we attempt to understand our identities over time and this identity will change over time. Therefore, the *'social construction of reality'* is determined by its actors as they engage in their everyday lives in *'bodies that experience the world'* through social processes using *'language'* to provide the detail that becomes the narrative ('narrative border' #3, the concepts).

4.7.2 Units of analysis

An important and basic component of this analytical framework involved deciding upon the units of analysis for the reason that it is those units of analysis that are guided by the research question and the methods of data generation (Downe-Wamboldt, 1992; Graneheim & Lundman, 2004). It is the two methods of participant-produced drawing and in-depth interviews which were utilised as they were "considered large enough to be considered a whole and small enough to be kept in mind as a context for the meaning unit" (Graneheim & Lundman, 2004, p. 106). These meaning units were created from the textual and visual data which provided what are known as 'sensitizing concepts' or interpretive devices which indicate analytical starting points (Blumer, 1969). Essentially, according to Blumer (1969, p. 148) these concepts lack specificity, and include such broad concepts as "culture, institutions, social structure, mores, and personality…" This lack of specificity Blumer (1969) argues is opposed to definitive concepts which prescribe a specific course of action and imply a singular, objective truth. Blumer (1969) rightly argues that the development of definitive concepts is problematic in the social sciences for the reason that in our naturalistic social world, phenomena and experiences are individually distinct, albeit socially informed.

4.7.3 Sensitising concepts

The development of sensitising concepts found its beginnings in my initial reflections following each interview, while I could still recall my first impressions of the most vivid aspects of that participant's overall narrative. Each reflection was audio recorded, and this allowed me the freedom to think

aloud. Examples of those reflections are presented in Table 4. Additionally, see Appendix N for a complete transcript of those initial reflections.

Table 4

Examples of Initial Reflections

Interview # and Pseudonym	Reflection	Sensitising Concepts
1. Irish	I'm thinking about the determination and the temporal aspects of this interview. It was a long time from original feelings of trans* being to a final eventuation of Irish. So many different aspects of time; the time of the surgery, the years since the surgery, all those 60 years of waiting to come to a point where it was time. And as Irish said it was the right time.	Temporality Identity
2. Phoenix	I'm wondering about the differences that Phoenix presents being a person born with a DSD. I didn't know she was intersex before the interview. I mean she had her trans*ness thrust upon her at birth. I suppose that in one way you could say her destiny was something set in concrete, and I think she was lucky not to suffer a surgical fate in infancy. Maybe that part relates to her spiritual journey, the spirit leaving the body as she spoke about, and although she was born that way, which I'm thinking is easier, she had some real issues mentally associated with that. That was interesting. That was weird too when she mentioned what the surgeon said about finding a nice man because he said exactly the same thing to me.	Identity Spirituality Health Biomedicine
3. Jeremy	Wow - I've entered a new area. I know nothing about trans* men and what they go through. Issues that hit me in the face were things to do with how a girl becomes a boy. I'd never considered it before now; why would a girl want to become a boy? – that seemed like a strange thing to do; turning femininity into masculinity and what type of man would Jeremy be was his take on it because he didn't like what he saw around him. I think for him non-binary is normality and that's a problem from a legal sense. He also highlighted the power of doctors and their influence; another issue we take for granted.	Stereotypes Identity Institutions Biomedicine

This initial impression of the data was consolidated following transcription where I began my immersion into the data using descriptive sorting techniques. This process teased out these concepts further and provided me with a general direction to pursue (Saldana, 2013).

Data analysis, similarly to data generation, is a nonlinear (Elo & Kyngäs, 2008), iterative and fluid process (Crabtree & Miller, 1999) which

demands immersion in the data generated with reference to the literature and other data not associated with the voice of the participant (St. Pierre, 2008). The point is that although the voice of the participant is important to the analysis, it is but one part of the data set alongside theorists, other researchers, experts, fictional characters, poets, artists, musicians and so forth. Other data are rooted in my individual bodily experiences and these may include emotional data and response data (St. Pierre, 1997).

Emotional data refers to the notion of sharing the lived experiences of my participants. How can a person not have an emotional attachment with people who are occupying similar spaces? All of their stories resonated in part with my own experiences and these experiences invoked a whole range of emotions which is cause for further reflection as I theorise my own existence. Response data are intersubjective since the feedback (responses) I receive from my academic supervisors, peers and other people in my social circle all contribute to my understanding of phenomena.

4.7.4 Development of the data frame

Analysing the textual and visual data from fourteen interviews, with each interview ranging in duration from 54 to 106 minutes and generating approximately 140,000 words of text and twelve reflective images initiated certain personal physiological and psychological responses. My inability to comprehend what I would do with the initial data set accompanied by nausea, neurological pain and fear of failure prompted me to take a reverse step and reconsider the analytical process. It provided the premise of timely reflection following transcription of all the interview data and my initial reading of the interviews. Under those circumstances, it was necessary to develop a

method of organising sections of data into a manageable construct with the intent of interpreting the perceived meanings of the content.

According to King (1998) and Crabtree and Miller (1999), interpreting data using a template is a flexible, convergent and time efficient organisational tool to store and sort segments of similar text. Equally important, documents (in this case, in-depth interviews and visual images) are social products which cannot be "treated as transparent representations of reality" (Hammersley & Atkinson, 2007, p. 130) which complemented the social constructionist approach of this research (King, 1998). The point is that the template as an organisational tool simplified the initial analytical process by sorting for the narrative content. This design essentially reduced the actual content of the data and allowed sorting segments of the data from the outset. An example of the template for the data frame using one of the narrative concepts and containing interview data including its related descriptive sorting techniques and analytical ideas to illustrate its structure is presented in Table 5.

Table 5

Example of Data Frame

Meaning units	Descriptive sorting	Analytical ideas
I very much fit the kind of classic. I was the 2 year old throwing tantrums about dresses. I hated having long hair. I tried to cut it off. I was the one who insisted in playing in the boys' basketball team and I managed to do so against the code until 15. I was very tomboyish, really into sports and things. (Jeremy, trans* male, age 29)	Remembering early childhood. First recollections of being different. Rejecting being a girl Acting like a boy Doing boys activities	Constructing gender Cultural Stereotypes **Narrative concept** Personal self
I was kind of on the boundary of how people would read me. So by that I mean I was sort of 50% of the time being read as male and 50% of the time being read as female, and all my existing friends and family were still using female pronouns and it felt strange asking them to change even though I knew I had to do that so in some ways it was kind of good because I got to Sydney and people just read me as male. (Jeremy, trans* male, age 29)	Thinking about the perceptions of others. Do they think I'm a boy or a girl? Confusion about pronouns. Asking for recognition as me. Removing doubt through relocation.	**Analytical ideas** Mental health Misgendering Passing **Narrative concept** Personal self

4.8 ETHICAL CONSIDERATIONS

4.8.1 Ethical approval

This project was approved by the QUT Human Research Ethics Committee (Approval Number 1200000502) as a low risk project (Appendix O) on the 8th October 2012. This approval was based upon the notion that there is always some level of risk with research that involves human participants. The people who were involved in this research have a personal interest in the health and wellbeing of the trans* population, and seldom get the opportunity to talk about the issues that are important to them. Some

trans* people would not feel comfortable talking about their personal situations with researchers who could be seen as voyeurs of deviant behaviour (James & Platzer, 1999). However, as principal researcher of this project and a member of the population under investigation, I developed an empathic connection to the participants and this allowed me to obtain a unique rapport with them. Disclosing my own situation enhanced participants' safety and is a technique I have successfully used previously with this population (Chaplin, 2011).

4.8.2 Variations to ethical approval protocols

During the course of this candidature, two separate variation requests were lodged with the QUT HREC, and the reasons behind the changes are described below.

Variation 1

The first variation (Appendix P) submitted April 4, 2013 and approved by the QUT HREC on April 5, 2013 reflected a change in the title of this thesis and some text in all the documents associated with the ethics application. As noted previously, I joined MGOV in late 2012 with a view to gaining access to potential participants and build rapport with the trans* community. Part of that process was to review the recruitment flyer and introductory email, which had been uploaded to the 'closed group' Facebook page. This initiated an online conversation between me and members of the group.

There were three main points of contention within the group and these were as follows:

- I used the word ‘transgender’ as a noun when it is an adjective that describes one of many attributes of a person who questions their biological gender
- I implied a label of ‘transgender’ as all-encompassing of the trans* phenomenon and is a label that was seen to impede recruitment of participants who do not identify with that label, and
- I implied that all trans* people identify as male or female by use of the word ‘opposite’ as in the phrase “identifies with the opposite gender” and by using the words ‘male’ and ‘female.’ By employing a binary framework of gender, it was suggested it could skew my results to a binary, normative outcome, and erase people who do not fit such binary concepts of gender.

I welcomed this constructive criticism offered by the group for the reason that it demonstrated the socially constructed nature of this research. The contributions of MGOV into the research process strengthened the relationships formed and empowered the group dynamic. As a result, the phrase ‘trans* and gender diverse people’ replaced the word transgender, and this reflected the diversity of the trans* population. It was suggested that this terminology was more likely to be better received by the trans* community and therefore recruitment would be improved. All references to the binary notion of male and female and the connotations they imply were removed from all ethics documents related to the current study.

Variation 2

The second variation (Appendix Q) submitted July 8, 2013 and approved by the QUT HREC on July 9, 2013 was necessitated by a change in the nomenclature associated with the diagnosis of Gender Identity Disorder (GID) when the DSM-5 (American Psychiatric Association, 2013) was published. As previously discussed, the DSM-IV (American Psychiatric Association, 1994) introduced the diagnosis of GID. In the DSM-5 (American Psychiatric Association, 2013), GID became known as Gender Dysphoria (GD) to reflect the variations in gender presentation/experience/expression and included those trans* people who stood apart from the traditional binary framework. Reference to GID was made in the original recruitment flyer and therefore this required amendment in this study's ethics documents.

4.8.3 Ethical merit and integrity, justice, beneficence and respect

Researching human participants is guided by the National Statement on Ethical Conduct in Human Research (NHMRC, 2007), and is underpinned by its four major principles. These principles are research merit and integrity, justice, beneficence and respect. The manner in which these guidelines assisted me in the conduct of this research is discussed below.

Research merit and integrity

According to the NHMRC (2007), human research may be considered to be meritorious if it has the potential to benefit its participants' health and wellbeing both as individuals and as a community. Equally important, contribution to the knowledge and understanding of a particular phenomenon may also be considered to be a benefit. The findings of the current study increased the level of understanding of the trans* phenomenon as it relates

to those individuals who decide to pursue a surgical approach to their dysphoria and will potentially benefit the transgender community and health practitioners by suggesting recommendations to the SOC [Version 7] (WPATH, 2011a) and to Australian legislative frameworks.

From an ethical perspective, the integrity of qualitative research is reliant upon its methodological rigour (NHMRC, 2007). Qualitative research is a field of inquiry that seeks to inquire about and explore social phenomena (Denzin & Lincoln, 2005; Hesse-Biber & Leavy, 2004). This research used a narrative inquiry methodology which relies on the social relationships formed between the researcher and the narrators. The temporal nature of the methodology gave the participants the opportunity to link the past, present and future and, for example, attempt to make sense of the changes to the body and other issues of importance.

Justice

According to the NHMRC (2007, p. 12), justice refers to the fairness of the research processes. These processes include the fair selection of participants where participants are not exploited and their participation in the research does not endanger them and the outcomes of the research are made accessible to them.

As this research focused on the experiences of those trans* people who have made the final transition, the research was naturally conducted using trans* people with the knowledge and attributes to provide the most detailed accounts of their experiences. However, the participants remained in control over the level of detail they wished to discuss during the research process. Additionally, all participants had the ability to withdraw from the research

without prejudice (Appendix R), thereby limiting their burden and minimising any exploitation.

Ethical consideration was also given to the dissemination of the findings and results to the participants following completion of the study. The approved QUT HREC protocol for this particular aspect of the research process is outlined below:

- Following examination and amendment to the final document, each participant will be contacted in writing to their preferred contact address to inquire if they would like a copy of the thesis
- A copy of the thesis will be sent if the participant expresses interest in receiving the results, and
- Each participant will be advised that feedback on individual results will not be possible due to the nature of the research

Beneficence

In research involving human participants, the benefits of the research must outweigh the potential risks to participants (NHMRC, 2007). It was recognised by this researcher that some participants may feel discomfort as they recall situations about their past or they may be related to participating in an interview. These incidents may be stressful if participants feel they are pressured to divulge information that may enter the public arena or have no control over what eventuates during the interview situation. At the beginning of the interview, they may feel competent in handling questions that evoke an emotional response, but emotion may take over when they actually recall some situations.

In managing these risks, prior to the interview, I began by telling participants that they were in control of any topics that were discussed. They were assured that if there were any questions they did not feel comfortable answering, they did not have to answer them. Additionally, at this juncture, I need to point out that each participant was advised prior to the interview that it was not my role as researcher to be a counsellor.

At any stage during the interview, if a participant showed signs of discomfort or anxiety, the interview was stopped and given the opportunity to take a break or end the interview entirely. Of the fourteen participants, one trans* woman did show signs of discomfort and became emotional about a specific incident in her life and the interview was terminated. I emphasised to her that she should feel no compulsion to continue discussing topics that evoke this type of reaction or indeed continue with the interview. After a short break, she decided to continue for the reason that she felt it was important to tell the researcher about these particular experiences which were difficult for her. In the final analysis, it was the participant's decision to continue or cease participation.

It was recognised that some participants may need support to deal with emotional or psychological discomfort from involvement in the research or anxiety as previously described. Therefore, counselling services through QUT Health Clinics were offered for Brisbane based participants. In addition, prior to the interview, all participants received a national list of trans* support organisations and counselling services (Appendix M) if they were concerned about their gender or health and were encouraged to contact if they

perceived the need to do so. From the above, it is apparent that there was a clear and effective strategy for managing the perceived risks.

Respect

A major component of the principle of respect is to uphold the principles of research merit and integrity, justice and beneficence as described above. This principle may also be considered to include the right for participants' identities to remain private when contributing to a research project and the right to be involved in their own decision making process as a research participant (NHMRC, 2007). Participants were not identified in this project. All data were protected during the study to ensure that participant confidentiality/anonymity was maintained. All comments and responses were treated confidentially and were made anonymous when transcribed.

Strategies to protect the anonymity and confidentiality of the participants included the use of pseudonyms, which the participants chose prior to the interview. Identifying features (for example, spouses' names and job descriptions) were omitted from the transcripts, the publication of this thesis and any future output of the research such as articles for external publication and conference proceedings, and access to the data was restricted to the research team. Additionally, the interviews were transcribed personally by the researcher as noted on the ethics application. The audio recordings (which were saved as digital files) and electronic copies of the transcripts and drawings were stored in U and H Drives at QUT in the researcher's personal folder. These folders are only accessible by the principal researcher and are password protected. Additionally, the password was changed regularly as per QUT's policies.

Furthermore, files on the digital recorder used to record the interviews have been saved as hidden files on the digital recorder and are only retrievable by the researcher. The audio recordings will be destroyed at the end of the project. The external USB drive to store working copies of the data, the digital recorder and any hard copies were stored in a locked filing cabinet in my private office at Kelvin Grove QUT. On the participant information sheet (Appendix J), it states that participant anonymity will be protected and that participation in the project is voluntary. Additionally, in accordance with data management procedures in place at QUT, all data will be stored for a period of five years before being destroyed. A copy of the detailed data management guidelines operational at QUT may be found at http://www.tils.qut.edu.au/initiatives/researchsupport/datamanage/planning.jsp#70.

4.8.4 Ethical dilemmas

High risk or low risk?

The participants in this study who had undergone SRS have been diagnosed previously with a mental illness (Transsexualism, GID or GD) and this was my first ethical dilemma. People with a cognitive impairment, intellectual disability or a mental illness are covered under Chapter 4.5 of the National Statement on Ethical Conduct in Human Research (NHMRC, 2007) and therefore must be reviewed and approved by the full committee of an HREC. Therefore, in my Honours project (Chaplin, 2011), I submitted a more than negligible or low risk application based upon that diagnosis. Nevertheless, in that research I argued that:

- it is considered that the majority of SRS recipients are no longer considered gender dysphoric once the surgery has been performed despite the fact that the diagnosis remains following SRS (Y. Smith et al., 2005)
- the nature of the condition would not preclude being able to obtain informed consent because of the intensive psychological and psychiatric evaluation that occurs over a period of two years prior to the surgery (WPATH, 2011b), and
- the risks to the participant would be limited to discomfort and not lead to distress also based upon this extensive evaluation (WPATH, 2011b).
-

When that project was finally approved, it was deemed to be low risk. For the very reason that that project was deemed low risk, I made a personal judgement and I approached the current study as low risk based upon the previous approval and the argument in that application.

Navigating the existing social network

The target population for the research was the postoperative trans* community. While the labels of 'transsexual' and 'transgender' are highly medicalised, being labelled in this manner also brings with it a sense of vulnerability due to social, legal and cultural circumstances (Dean et al., 2000). Given my position as a person with shared lived experience of the population under investigation, there was a possibility that potential participants may have been known by me or by association.

Although the actual numbers of trans* people in Australia is unknown, as previously noted, it was a reasonable assumption to suggest that the population was large enough to avoid this situation and therefore I dismissed it as an issue at the time. Anecdotal evidence by virtue of the number of transgender support organisations in Australia used for recruitment and the estimates of the Equality and Human Rights Commission (2012) suggested that the incidence was greater than the results of a prevalence study by Ross et al. (1981). Also, in recent times, there has been a greater willingness of some transgender people to 'come out' and be recognised. Equally important, there has been some recognition by governments and organisations around Australia that all trans* people do have special needs regardless of their operative status (National Health and Hospitals Reform Commission, 2008; National LGBTI Health Alliance, 2012). One internet based study conducted in 2007 (Couch et al.) yielded 229 Australian self-identified trans* participants. More recently, another internet based study (Hyde et al., 2014), 946 trans* people participated, but the potential number would be greater than that on a national basis.

Nonetheless, when I joined the MGOV support group and when I presented a paper at the Transgender, Sistergirl and Gender Diverse Conference in Cairns in 2012, I created a situation whereby those associations were formed and I had my own network of trans* associates from 40 years of living as such. Although it was never my intention to recruit any one that was personally known to me, it remained a distinct possibility for the duration of the recruitment phase of the project. However, the practicality of recruiting meant that three such instances occurred whereby I knew the

potential participant. Two of the trans* women I had previously met at the Transgender, Sistergirl and Gender Diverse Conference held in Cairns, Australia in 2012. The third trans* woman was a member of MGOV. In those particular instances, I made it very clear to those three people that any decision to participate in the project was their decision to do so on a voluntary basis and that our existing relationship did not obligate them to participate.

Financial incentives

Each participant was offered a small cash incentive ($20) as reimbursement for their time to cover incidental expenses such as parking and travel to the interview site. This is sometimes viewed as a controversial topic for ethical reasons (Grady, 2001; Mapstone, Elbourne, & Roberts, 2007; NHMRC, 2007; Tishler & Bartholomae, 2002). However, it is a research method that is often employed to recruit participants where the topic could be interpreted as sensitive, or where the participants were hard to find, such as in the current study (Renzetti & Lee, 1993).

According to the NHMRC (2007), reimbursing participants for incidental costs such as travel, parking and time involved is acceptable so long as the payment is not excessive. Furthermore, Grady (2001) considers that reimbursement respects the contribution of participants to the research process. It was considered by this researcher that participants should not be financially disadvantaged for their time. From previous experience, interviews last approximately 90 minutes (Chaplin, 2011), and therefore a nominal amount of $20 to cover costs was justified in this instance. In order to ensure ethical transparency and rigour, full disclosure of the

reimbursement was made in the participant information sheet (Appendix J) and informed consent document (Appendix K).

As it was a cash transaction, it was not be possible for reasons of anonymity/confidentiality to receive a signed receipt from the participants. In order that the money was accounted for and claimed from my student allocation, I kept a record of all interviews (Appendix S). Once interviews were completed, the record was totalled and a Statutory Declaration was completed and duly witnessed by a Justice of the Peace (Appendix T). However, on five occasions I forgot to offer the incentive at the time of the interview. In those instances, I contacted the participants either by SMS or email to offer the incentive. Three participants replied but none required the incentive. For the two that did not reply, I could only assume the incentive was not required. On reflection, this should have been noted on the interview checklist (Appendix D).

4.9 EXPLORING TRUSTWORTHINESS

4.9.1 Validity and truth

> The goal of validation is not to determine, once and for all, if a representation serves a particular function, but rather to discover and anticipate how it "does," "can," or "might," function to incite and foreclose, emancipate and oppress, and so forth when applied to different times and contexts and evaluated from different social locations. (Aguinaldo, 2004, p. 134)

The words of Aguinaldo (2004) above causes us to reflect on the validity of research. Such concepts as validity and truth have long been interpreted as questionable and problematic attributes of qualitative research (Pillow, 2003b) for the reason that the findings generated cannot be

generalised to entire populations – an objective, singular, universal reality (Lincoln, Lynham, & Guba, 2011). The *Oxford Dictionary of Sociology* defines validity as "the property of being genuine, a true reflection of attitudes, behaviour or characteristics" (Scott & Marshall, 2009, p. 786), and this too may be seen to represent a singular truth depending upon your interpretation of that definition. However, my views on knowledge and truth encapsulate certain nuances of the postmodernist perspective in that "there are multiple ways of knowing and multiple truths" (Kvale, 2002, p. 301). As Kvale (2002, p. 302) suggests, the concept of affirmative postmodernism provides a way forward to the existence of multiple truths and realities by "accepting the possibility of specific local, personal and community forms of truth." In that respect, validity in qualitative research is directly linked to the context in which research is undertaken. These realities may or may not be "accurate reflections of actual events" (Hammersley, 2008, p. 479) but the research material generated in conjunction with existing literature and theories is indicative of the "meanings people attach to those events." Furthermore, the level of detail provided in the 'ways of doing' this research contributed to the transparency of the present study for the reason that in the qualitative paradigm, an audit trail is an essential component of the socially constructed validity of a study (Kvale, 2002). In the words of Altheide and Johnson (2011, p. 586):

> The idea is that evidence is not about facts, per se, but is about an argument, a narrative that is appropriate for the purpose-at-hand. That means it is contextualized [sic] and part of a bounded project, with accompanying assumptions, criteria, rules of membership, participation, and so on.

According to Pillow (2003b, p. 179), it is these ongoing debates on validity in qualitative research that have situated reflexivity as being "important to demonstrate one's awareness of the research problematics."

4.9.2 Reflexivity

Contextually, this study involved the lives of 14 trans* people who had undergone SRS being researched by another trans* person who had undergone SRS. There is a complex relationship between knowledge production and the processes in producing that knowledge by the researcher. This aspect is particularly relevant to my sharing certain aspects of the lived experience with the participants in this study. It is necessary for me to reflect on that lived experience in that my narrative is proximal to the research itself. Drawing on Alvesson and Sköldberg (2009, p. 269):

> Reflection means thinking about the conditions for what one is doing, investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction, with whatever is being researched, often in ways that are difficult to become conscious of.

I brought to this research my own perspectives of the trans* community and individuals within it. I have lived the life of a trans* woman for the majority of my life in a variety of social and geographical locations, each of which has their own legal and cultural variations. I have reflected my views throughout this thesis where appropriate for the reason that it is necessary to undertake this type of reflexive activity from the outset. Indeed, some would say my views are conspicuous. For Aguinaldo (2004, p. 132), reflexivity involves writing "in the first person to foreground my performance (and hence my accountability) as the researcher."

Sharing lived experience brings with it the possibility of similar outlooks. Interestingly enough, elements of each narrative could be superimposed on my own narrative and this emotional attachment in some way drove my formation of those narratives. This particular notion is reflected in the nuances of some of the interviews where there were inferences by participants using language such as "you know what I mean," and "I don't need to tell you about this stuff" and other times of shared silence and laughter. Nonetheless, the similarities between me and the other actors in this discourse were also in some ways short-lived, as many of the attributes which appeared throughout the narrative threads were alien to my world. I was both an insider and an outsider in this research. In the words of St. Pierre (1997, p. 178), "I was like them but different too…I was both identity and difference, self and other, knower and known, researcher and researched."

4.9.3 Beyond insider vs. outsider: occupying a shared space

From St. Pierre's (1997) words above, it becomes apparent that tensions exist as an SRS recipient researching SRS recipients. However, it is not as simple as occupying a space that Breen (2007) and Dwyer and Buckle (2009) refer to as the 'insider-outsider' in qualitative research. As Dwyer and Buckle (2009, p. 60) note, "to be considered same or different requires reference to another person or group." In other words, despite my insider status, the nature of the research process and the heterogeneous composition of the population (or context), this dichotomous view of insider-outsider does not allow for the nuances of sameness and difference, the

movement between the two spaces or indeed the manner in which this research proceeded.

I have explicitly acknowledged my insider status from the outset as sharing lived experience. From this revelation, my insider position would appear to indicate a biased and somewhat homogenous approach to this research. From my perspective, the homogeneity is grounded mainly in biological perspectives. Firstly, we are a homogenous group of people who pursued SRS as an outcome to relieve the constraints placed upon us (me and the participants) by a biology that was diametrically opposed to our psychological world and therefore our sameness is reflected in reclaiming our innermost identities. Secondly, as a trans* woman, I can relate to the sameness of the physical surgical act as a lived experience to replace a penis with a vagina. Another aspect of our sameness is the way in which society and its institutions have classified our collective existence on the periphery of social acceptability. If it wasn't for these aspects of sameness and the association between them created to pursue this research, this research probably never would have been undertaken. However, according to Fay (1996, p. 241), knowing the self cannot be sustained without "our knowledge of others," but it is not a relationship that is polar opposite; one can move between these supposed dichotomous entities (Fay, 1996).

Here, I need to not only expand upon my position as outsider, but to transcend the insider-outsider dichotomy and place my role in this research as occupying a shared space between those problematic extremes. My outsider status first became evident during data generation and the very first interview with a trans* man; where difference was overtly manifested along

gendered lines.[70] The embodied experiences of trans* men were beyond my knowledge. It was at this time I conducted three interviews with trans* men in close proximity to each other, therefore my outsider status became polarised as I was fascinated by their physicality and their views of transitioning. However, by the time I was interviewing Jimmy, I commented to him "I don't know a lot about trans* guys so…yeah so hearing about their process is really quite eye opening for me." And then a further comment in the same interview which encapsulates the notion of the shared space, when I mentioned: "yes…there is a similarity but there is a difference." It is here that the dichotomous notion of insider-outsider becomes unravelled. As suggested by Dwyer and Buckle (2009, p. 60), "as qualitative researchers we have an appreciation for the fluidity and multilayered complexity of human experience." The socially constructed nature of this research brings with it this notion of fluidity between and beyond sameness and difference through the existence of a dynamic relationship with the participants.

4.10 SUMMARY

In summary, this chapter discussed and justified the research methods employed in the conduct of this study. Discussion centred on the key tenets of the research process. These included the use of purposive sampling in order to obtain participants with lived experience of the SRS phenomenon who satisfied the selection criteria. Additionally, detailed descriptions of how the participants were accessed and recruited and the demographic profiles of

[70] See Table 4, and my initial reflection on Jeremy's interview (my first interview with a trans* man).

the participants were offered. Data generation and analysis techniques were fully described and justified. Ethical considerations and certain ethical dilemmas faced during the research process were fully explained. The discussion concluded with the rigour of this socially constructed study, including a discussion on validity and truth, reflexivity and my position as a researcher who occupied a shared space of insider-outsider.

In the following section, an overview of the research findings will be presented, which depicts the narrative concepts that were developed, and is constructed around the narrative content threads of navigating the personal, social, medical and legal self, as a trans* person pursuing SRS. Chapter 5 is concerned with the discussion of the processes involved with the personal and social selves, while Chapter 6 deals with how the participants in this study negotiated their medical and legal selves

Introducing the research findings

As previously suggested, there is a lack of knowledge associated with the psychosocial experiences of trans* people negotiating surgical transition in the Australian context. WPATH (2011a) advocates for increased knowledge as they apply to local contexts as the majority of research into the health and wellbeing of trans* people is and has been traditionally conducted in Europe and North America. The current study addresses that specific problem. The findings of this study represent a whole of life approach to the trans* phenomenon in Australia. The research indicates that the decision to undergo a surgical process can have its roots in childhood on a personal and social level and that transition processes continue throughout adolescence and adulthood. Upon approaching and reaching adulthood, the participants' attention turns to the medical/surgical and legal aspects of the transition. The everyday actions of the individual going about their daily life intersect with medical and legal processes. The following work explores the intersection of these dimensions and documents the participants' views on the inconsistencies in healthcare provision. Furthermore, for the participants, the extremely complex legislative framework is viewed as unworkable.

The legal inconsistencies contribute to the continued social discrimination, institutional erasure and systemic oppression for trans* people in what is often referred to as a socially progressive society. It is these personal, social, medical and legal realities which occupy and permeate our everyday worlds; our "paramount reality" (Berger & Luckmann, 1966, p. 25). Chapters 5 and 6 explore those experiences as the participants navigate

their personal, social, medical and legal selves. An overview of the narrative concepts is displayed in *Figure 3* below.

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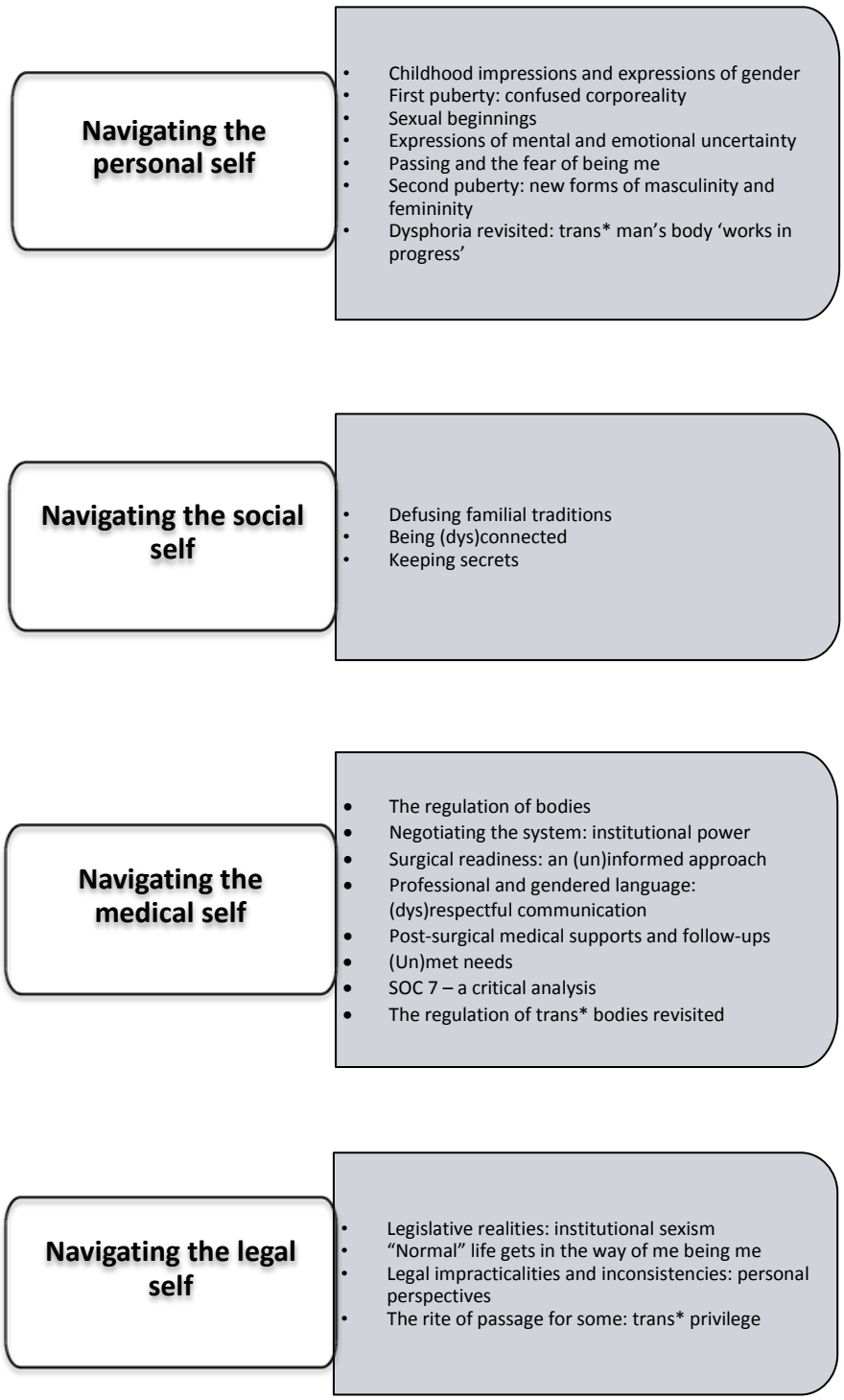

Figure 3. A summary of the narrative concepts

The narrative construction that follows provides a whole of life depiction of the SRS experience which is grounded in the data. For these participants, reconciling past events with the present highlights their unique positioning as narrators of their own experiences. At this time, it is important to remind the reader that the participants' accounts are more than mere quotes; they represent extremely personal accounts of their everyday lives as stories lived and told and go some way into explaining the complex and nuanced nature of being a trans* person.

Chapter 5: Ways of interpreting: personal and social selves

> *Well there was a time when I suffered severe depression and I suppose that was associated with my trans* issues, but I was into the drugs and alcohol for a while because of the pain; the pain of never knowing where I actually fit in the world at one point in my life. And I felt I was in the wrong body and that was extremely averse to anything I knew or understood. (Dee Dee, trans* woman, age 49)*[71]

5.1 INTRODUCTION: PSYCHOSOCIAL CONFESSIONALS

Dee Dee's words above reflect the complex nature of being a trans* person and the struggles sometimes associated with pursuing a life where mind and body are dissonant. The life journeys of trans* people such as Dee Dee do not necessarily meet the expectations of wider social networks; familial or societal. Nonetheless, for Dee Dee, and indeed, all the participants in this study, SRS was a medically necessary treatment to align disparate bodies and minds. The decision to undergo such radical treatment was not a process that was done in isolation, taken lightly or without wider personal and social consequences. Psychosocial issues such as depression, substance abuse, not belonging and low self-esteem are a part of the everyday existence of some trans* people such as Dee Dee.

This chapter explores the varied experiences of the participants in this study in order to provide a rich understanding of the personal and social selves and the issues encountered while pursuing SRS in the Australian

[71] To remind the reader, all the participants' identities remain anonymous and are known by pseudonyms throughout. Additionally, the identifier used (trans* woman, trans* male, female, male) is taken from the self-identified statuses of the participants. (See Table 3 and Section 4.5.1).

context. It does this through an interpretation of data generated through interviews and participant produced drawings. The significance of the work lies in its unique conceptual framework which highlights the complexity of transition from a whole of life approach.

5.2 NAVIGATING THE PERSONAL SELF

5.2.1 Childhood impressions and expressions of gender

For many trans* men and women, SRS is that point in the journey where self-realisation and an authentic appreciation of self is fulfilled. Nonetheless, gender dysphoria and the journey towards SRS often have their beginnings in childhood. Dysphoria can mask the true self as socialisation during early childhood is generally based upon the assigned sex at birth. For Berger and Luckmann (1966, p. 132, emphasis in original), "the child learns that he *is* what he is called," and the child assumes and internalises that identity. This approach to identity development is typically associated with a binary framework of sex and gender. In contrast to this assumed phenomenon, in this study, personal self-awareness was navigated along gendered lines as 'boys will be boys' and 'girls will be boys'. Natal girls were openly being 'tomboyish' but natal boys hid their sense of the feminine self or remained genderless. Participants' accounts of this sense of self diverge from K. Johnson's (2007) views that transsexuals go through a process of becoming male or female through transitioning to a new gender identity. Instead, it is about matching the identity the participants already embody, as suggested in the following account:

> *I very much fit the kind of classic. I was the 2 year old throwing tantrums about dresses. I hated having long hair. I tried to cut it off. I was the one who insisted in playing in the boys' basketball team and I managed to do so against the code until 15. I was very tomboyish, really into sports and things. (Jeremy, trans* male, age 29)*

Being born in the wrong body (Sullivan, 2008) conveys a sense of the dominant 20th century transsexual narrative and the label that transsexual implies (Benjamin, 1966; Kaufmann, 2010). As Sullivan (2008, pp. 106-107) goes on to state, "the trope of the wrong body has undoubtedly played an enormously persuasive role in the demand for, access to, and justification of sex reassignment surgeries." Its implication is plotted as a "sex-gender misalignment" (Kaufmann, 2010, p. 105) where Jeremy acts out his masculine embodiment through rebelling against the cultural stereotype of what a young girl should do and be. These active perceptions of the 'real me' from an early age continue through childhood into early teens in defiance of taken-for-granted social norms and is exemplified by assuming a male role. The masculine ideal is embodied in strength of insistence to the point where it is no longer sustainable as a blossoming teenage girl. However, the classic narrative also brings with it another reality; the possible realisations that you're not what you know you are despite others' perceptions of you:

> *Funnily I think I thought I was just a little boy until I went to the pool at the age of 4. I think I actually thought I was the same as all the other little boys and then I found out I was different and not alike. But I guess then I was a tomboy, so I knew I was different and then when I was a kid I did a lot of sport. And I always got mistaken for a boy when I was a kid. I knew fairly young that people were perceiving my gender ambiguously. (Jimmy, male, age 33)*

Others' perceptions of a typical masculinity are entangled in a body schema that contradicts masculinity despite a personal and social

acceptability of occupying a male space. Drawing on Berger and Luckmann (1966, p. 50), navigating the self is both an individual bodily experience (what they term 'organismic') and a social process that is navigated through our association with those who occupy significant spaces in our social world. The thought of occupying a male space when the corporeal reality of a boy having a vagina goes against those taken-for-granted norms of gender in a binary sense, creates internal confusion and this diversity can result in social rejection:

> *I just had this overwhelming sense of being different always from a very young child. You know I was always mocked. They called me (nickname) at school which was 'boy-girl'. I was always a tomboy. (LM, male, age 27)*

LM's social rejection by peers through the language of 'boy-girl' aligns with the findings of R. Green, Williams, and Goodman (1982) in their longitudinal study of 99 (what they refer to as traditionally sex-typed and non-traditionally sex-typed) females. In that study, the 'non-traditional' girls were often regarded as loners or not socially conversant with their female peers. Despite this ostracism, the data also suggests a social acceptance and recognition of self that indicates it's socially acceptable to role play the boy. This particular aspect also reflects the findings of R. Green et al. (1982, p. 256) through the 'non-traditional' girls' ability to socialise with boys instead of girls in sports and "rough and tumble play." In contrast, the realities of some natal males in this research suggest an alternative transition trajectory:

> *Well my childhood was confusing. I had the body of a boy that I just disassociated from it. You learn when you're a young age, you can't be a sissy or effeminate and you just struggle to fit in. You feel like you can't connect with boys and you can't connect with girls because sexually you're meant to be a boy. The thing is socially, you don't fit*

> *with boys, so live on the fringes of male and female. (Ms Mel, female, age 50)*

The dominant transsexual narrative persists of living in a body that doesn't fit. However, Ms Mel avoids a female embodiment in favour of a traditional, stereotypical male embodiment. This estrangement from the biological reality of being a boy invokes feelings and behaviours of not belonging to either gender, yet at the same time creates a situation (another reality) of reinforcing masculine behaviour in the social world. This aspect reflects what Berger and Luckmann (1966, p. 147) argue is the inevitability of primary socialisation of the assigned sex (meaning gender). Furthermore, drawing on Goffman (1963, p. 95), this particular notion creates a form of stigma "because of the great rewards in being considered normal." Therefore, this masculine embodiment defies the sense of 'being me' by succumbing to a socially acceptable form of personhood that also embodies a sense of aloneness. This sense of aloneness can also invoke an 'unknowing of me' which stems from social and familial upbringings, as suggested by the following participant:

> *So I think that's been a nice example of going from someone very stressed and very closeted and nine years in a Catholic school; not the place to be to a point where I've got my image out there and the nature of the image questions my gender identity from a very young age… (Buffy Dunlop, female, age 44)*

For Buffy, the dominant narrative exists, albeit reflexively. The gendered embodiment of this 'unknowing' identity suggests both a genderless sense of self and a childhood socialisation that she took for granted and enforced a traditional male persona. If you are born a boy, you must be male and

masculine, reinforcing Berger and Luckmann's (1966) concept of inevitable socialisation. Another "unknowing" identity is a genderless state as a child who adopts a male embodiment for the majority of her life is suggested below by one participant:

> *I'd known since I was 6 that I was wrong – something was wrong but what the hell it was. I'd had the opportunity when my first marriage ended in divorce. I suppose at 66 I never thought that I would ever achieve what I wanted; to have known for 60 odd years that this is what should be. (Irish, female, age 78)*

The social construction of masculinity and its association with power and dominance denied the emergent femininity with its notions of weakness and submissiveness. This association is historically situated in an era where deviation from the social norms of masculinity and femininity was considered pathological by the patriarchal medical community (Minton, 1986) in particular and society in general. As stated by Zamboni (2006), death or divorce is often a catalyst for change; however, for Irish, that was not a reality. This finding suggests it is more socially acceptable to act out masculine selfhood than it is to act out feminine selfhood as is played out in Enid Blyton's (1978, p. 31) fictional literature of the 20th century.

> "I don't see why George shouldn't come," he said. "I bet she'd be every bit as good as a boy. I thought she was one when I first saw her." George gave him one of her sweetest smiles. He couldn't have said anything she liked better.

The actors in the above discourse display striking similarities to the participants' accounts. This social construction of gender is indicative of a non-binary framework where it is not those biologically ascribed signifiers of gender that determine the man or the woman but those learned, socialised

behaviours of being masculine or feminine. This is particularly applicable to all the trans* men in this study as their 'bottoms' are biologically female but they all pass as male, much like Blyton's (1978) George. However, it is also argued by Whittle (1999a, p. 16) that there is no privilege in being a trans* man even though he passes as a man, he is still legally a woman or "a trans man with a transsexual status." In stark opposition to this view, Jeffreys (2002) believes that trans* men are betraying their lesbian bodies and engaging in an act of "social climbing." From another perspective, Nordmarken (2014), a trans* man teacher perceives student respect positively with his transition.

In contrast to the non-binary framework above, Berger and Luckmann (1966, p. 168) consider that defying the norms of what they term sex (meaning gender), is an example of "unsuccessful socialization," where the child can be labelled an "abnormality." Berger and Luckmann (1966) explain this social construction of reality in terms of the child making the "wrong choice" based upon identifying too closely with the "other sex." "Othering" and "wrong choice" typify the notion of the assumed binary nature of sex and gender, as Berger and Luckmann (1966, p. 168, emphasis in original) explain here:

> For example, a male child may internalize "improper" elements of the female world because his father is absent during the crucial period of primary socialization and it is administered exclusively by his mother and three older sisters. They may mediate the "proper" jurisdictional definitions to the little boy so that he knows he is not supposed to live in the women's world. But he may nevertheless *identify* with it.

Contextually, this approach to the social construction of gender is akin to the nature/nurture debate of the 1960s where it was theorised that gender

variance itself could be socially constructed and that infants could be sexually reassigned and socialised in the reassigned gender. One such case (John/Joan) was "presented to the world to demonstrate the so-called power of nurture to overcome nature" (Diamond, 2005, p. 76). This approach to gender construction is a theory that was later effectively refuted (Intersex Society of North America, 2008a, 2008b) when David (John/Joan) Reimer[72] was surgically reassigned as an infant and in later childhood reverted back to his biologically assigned gender role.

Perhaps fortuitously, it was recognised as early as 1980 when transsexualism first became a diagnosable mental illness in the DSM-III (American Psychiatric Association, p. 264) that a dissonance exists for some boys and girls who go against the cultural stereotypes of masculinity and femininity. According to the American Psychiatric Association (1980), children who display such tendencies do so with a strong desire to be of the 'other' sex and act out the preferred self socially. For example, boys would play with dolls and girls would have greater participation in sports. This type of thinking continues currently in the DSM-5 around the discussion of the diagnostic criteria of GD (American Psychiatric Association, 2013). Although a diagnosis of GD (American Psychiatric Association, 2013) has softened somewhat from the previous diagnosis of GID (American Psychiatric Association, 1994, 2000), the diagnostic features continue to be heavily weighted towards the traditional gendered stereotypes that exist within a

[72] David Reimer was surgically reassigned at the age of 18 months following a surgical accident during his circumcision. His parents were convinced by medical authorities of the day that the surgery would make David a girl physically and socially because of his age at the time of the procedure.

binary gender framework of male and female. This approach both objectifies and subjectifies the notion of gender despite the recognition of "some alternative gender different from one's assigned gender" (American Psychiatric Association, 2013, p. 452). The findings suggested by this study both converge and diverge from those ideas along gendered lines. Trans* men clearly displayed tendencies of masculine behaviours as children. However, some trans* women's impressions of childhood conveyed a sense of avoidance or ignorance of femaleness.

5.2.2 First puberty: confused corporeality

This childhood image of self loses its innocence and translates itself into issues surrounding body image and self-loathing at 'first puberty'.[73] Body image, which can be defined as "one's perception of and satisfaction with his or her body" (Fleming, MacGowan, Robinson, Spitz, & Salt, 1982, p. 461) has long been a signifier of the trans* phenomenon (Pauly & Lindgren, 1977), where mismatched minds and bodies are compelled to come to terms with that unwanted maturing body and all its nuances involved in the making of young men and women. The teenage years in the heteronormative world are a time of identity confusion as Erikson (1980, p. 98) recognises:

> [Identity confusion is] unavoidable at a time of life when the body changes its proportions radically, when genital maturity floods body and imagination with all manner of drives…and when life lies before one with a variety of conflicting possibilities and choices.

[73] Those trans* people that find their expression of gender through hormonal and surgical processes experience two puberties, firstly as a teenager in their natal form (if puberty blockers have not been used) and secondly in their transfigured form, once the effects of those hormonal and surgical therapies have been felt.

For trans* people, an extra layer of complexity exists as feelings of ambivalence about body parts and those primary and secondary sexual characteristics take shape. From Langer's (2014) perspective, the manner in which trans* people construct their body image is seated in the unconscious realm. From a social constructionist perspective, it is not just the dissatisfaction with those sexual characteristics that becomes apparent in the first pubescent state. It is how they are experienced on a daily basis, as explained by one participant:

> *Well I started developing breasts when I was…it was pretty early…I think 10. And then in Year 6 when I was 12 years old, they started growing so I used to wear jackets all the time, even in summer just to cover it up. And the periods made me feel pretty bad as well and that was just horrible, but I thought, that's just normal; this happens to everyone; like every girl, but then as the years went by, it just got worse and then in Year 11 and 12, Year 12 was the worst because I just couldn't live any more with that body. (Daniel, male, age 25)*

The budding of breasts is a welcome signifier of female embodiment at puberty for cisgender women and female sexuality is often displayed with short crop tops and bikinis. Breasts signify transition to womanhood and their visibility is the cisgender woman's rite of passage. For Daniel, their growth and their visibility is a signal that his body is betraying his mind and they detract from the male embodiment with which he identifies. Concealing clothing was used to disguise femaleness and create the illusion of a masculine physicality. For Ekins and King (1999), concealment is considered a classical attribute of trans* peoples' identities. The betrayal associated with burgeoning breasts was heightened further over the years with the one signifier of female embodiment that distinguishes man from woman – menarche and the menstrual cycle. The concept of bodily betrayal supports

Williams, Weinberg and Rosenberger's (2013) findings where trans* men spoke of their vaginas as 'traitors'.

For one participant, the constant reminder of femaleness in the menstrual cycle increased the feelings of dysphoria and in some cases pain.

> *I was just a kid but I do remember feeling like weighed down by it [puberty]. I mean when girls say to me things like "I don't mind getting my period because it makes me feel like a woman" and then I think 'Fuck! That was like the worst part of my life.' You know…it was just yuck. It felt [like] this pointless infliction of pain and I just hated it. (Leroy, male, age 31)*

It is this pain that Langer (2014) argues trans* people need to experience in order to fully appreciate the extent of the body modifications, if any, required to dissipate the pain. As Merleau-Ponty (2012, p. 96) notes, the body is an affective object and this pain is "constitutive of a 'pain-space'," denoted by the offending ambiguous body parts. Vitale (2010), on the other hand, views those adolescent years for trans* people as merely another time of waiting that is characterised by disappointment and confusion with its unwanted feminisation and/or masculinisation. Vitale (2010) rightly associates the maturing and classical trans* body with grotesqueness and indignity. Participants' accounts of 'first puberty' is consistent with Vitale's (2010) views on those unwanted, ambiguous body parts and the waiting game. In contrast, I would argue that body image for those pursuing SRS is located in the conscious arena, and not in the unconscious, as Langer (2014) suggests. The intense physicality of maturing body parts which are grotesque, as Vitale (2010) argues, implies a consciousness of those ambiguous body parts.

5.2.3 Sexual beginnings

Merleau-Ponty (2012) informs us that, indeed, ambiguity is synonymous with human existence and expresses itself sexually. The confusion and the pain associated with developing those unwanted gendered attributes at that time typically coincides with a sexual confusion. How does a gender confused person negotiate this process amid the maelstrom surrounding their being? Sexuality and sexual orientation are often conflated with gender, particularly when approached in tandem with trans* people. It is indeed an incorrect assumption that trans* people are automatically gay or lesbian, or that being trans* is in itself a sexual orientation (American Psychological Association, 2011). In the current study, participants' accounts of their sexuality and sexual orientation indicate a polychotomy of sexualities and orientations during and beyond first and second puberties, all of which are valid outcomes albeit confusing to the cisgender, normative world. This polychotomy of sexualities is indicative of the complexity of the trans* phenomenon:

> *I've never been attracted to women; part of the confusion why it took me so long to work myself out because if I'm in a female body and I'm attracted to men, I must be a female. It took me a long time to…I could be a gay man. I identified as a gay man. And I was still looking terribly female. I had long hair and double D tits. I didn't get away with hiding this easily. (Andrew E, male, age 48)*

For this participant, there was an assumption that occupying a female space with visibly female body parts was an automatic cue to a heteronormative sexual orientation. Similarly to the trans* women in this study who denied their innate identity as children, there existed an embodiment that could be conceptualised as a successful socialisation

(Berger & Luckmann, 1966). This assumption implies an 'unknowing of me' based upon previous relationships with men and suggests that the confusion over sexual orientation is associated with the trans* phenomenon. Over time, the thought processes to replace his female embodiment with the masculine ideal create an alternative sexual reality. Similarly, this confusion about the binary nature of orientation can equally apply to trans* women and is reconstituted in reverse:

> *I don't have to be a gay male to be a trans* woman. That was something else. My head was stuck in this binary notion concerning sex, gender and sexuality. I had to shift away from that. And then when I understood that there were trans* lesbians this makes sense now you know. (Ms Mel, female, age 50)*

Nonetheless, the heteronormative embodiment of man and woman remains with some; it is embedded in lifetime habits and having SRS does not dissuade from that straight orientation or residing within the binary framework, as suggested by the following participant:

> *I had done what I thought I was mentally attuned to do in two ways; to have surgery when the time was right [at 66] and I had 2 very happy marriages – sounds weird – kids, grandkids, now great grandkids. (Irish, female, age 78)*

This straight down the line approach suggests the existence of two separate, set in concrete lives – I was once a man and now I am a woman. It also suggests a sense of comfort with the conventional roles of masculine and feminine and an ability to use society's conventions to fit in. According to Ettner and Monstrey (2007), although elderly trans* people have been incidentally included in previous studies concerning SRS (Eldh et al., 1997; Landén, Wålinder, Hambert, & Lundström, 1998; Lawrence, 2003), there is

no research conducted specifically with elderly trans* people who pursue SRS as an outcome to affirm this suggestion. Recent research conducted with elderly trans* people is concerned with the ageing process in this population (Croghan, Moone, & Olson, 2014; Van Wagenen, Driskell, & Bradford, 2013). Being lesbian or gay brings with it an added layer at the social level by suggesting that it is possible to avoid some discrimination and be more socially acceptable as a trans* person if you're straight. However, if you're gay or lesbian, you tick two assumed deviant boxes from a heteronormative perspective, and the chances of stigmatisation are greater. Sexual orientation can also be a fluid process, as the following account suggests:

> *I lean towards being heterosexual with some bisexual tendencies although I have no interest in having sex with other women [other than my wife], so that's why I have some difficulty in trying to give that an answer, so maybe I'm just heterosexual – (laughter) – or maybe not. (Dee Dee, trans* woman, age 49)*

The sexualities represented here are reflected in other recent studies (McNeil, Bailey, Ellis, Morton, & Regan, 2012; Riggs & Due, 2013). McNeil et al. (2012, p. 11) reported eleven different orientations in their study on the mental health of 912 trans* people in the UK, being bisexual, queer, straight or heterosexual, pansexual, BDSM/kink,[74] lesbian, not sure or questioning, other, don't define, gay, polyamorous[75] and asexual. In a recent Australian online survey (Riggs & Due, 2013) which looked at the health care experiences of trans* people from the viewpoint of the differences between assigned and preferred gender, sexual orientation was self-reported as gay,

[74] BDSM is the acronym of bondage, discipline and sadomasochism.
[75] Polyamory is concerned with having loving relationships with multiple partners.

heterosexual, bisexual, queer, asexual, and pansexual. Similarly, other Australian studies (T. Jones et al., 2015; E. Smith et al., 2014) reported equally diverse sexual orientations. Participants' accounts of sexuality also supports Merleau-Ponty's (2012, p. 163) view that man's sexuality is ambiguous, things sexual are intentional acts and are "learned through our bodily experience." These experiences are congruent with Doidge's (2007) notion of sexual plasticity which is concerned with human variations in sexual activity, partners and attractions. The findings confirm that being trans* is not a sexual orientation (American Psychological Association, 2011) as the participants made a conscious effort to align their sexuality with their diverse bodily experiences. Confusion about sex, gender and body image can also affect and may or may not be intrinsically linked to one's mental health and I now explore those issues.

5.2.4 Expressions of mental and emotional uncertainty

Issues surrounding the mental health of trans* people such as depression, anxiety, attempted suicide, suicidal ideation and substance abuse have long been portrayed as symptoms of the pathology of being trans*, as previously discussed. These issues, which may or may not be linked to being trans* exist to the point where depression, anxiety, suicidal ideation and so on may become the new realities (Bockting et al., 2006; Haas, Rodgers, & Herman, 2014; Pitts, Couch, Mulcare, Croy, & Mitchell, 2009). The trans* phenomenon may mask those psychological issues just as those psychological issues may mask being trans* itself. In the current study, several participants reported presenting with mental health issues directly related to being a trans* person. These presentations may or may

not have been diagnosed or diagnosable but remain related to being trans* and mark a point in searching for self and personal identity that was masked by being trans*, as participants' accounts relate:

> *I've always been suicidal. From a very early age like probably from 16/17 was my first attempt. I was just very traumatised; traumatised by my family's inability to deal with who I was even though there was information for them at hand in terms of my XXY chromosomes, so they knew that when I was a little child – they knew I was different and I used to say I'm a girl, I'm a girl. (Phoenix, female, age 42)*

A chromosomal variation places some trans* people such as Phoenix in a precarious place as there is a distinct physical attribute which is directly linked to their embodiment, much the same as an intersex person with ambiguous genitalia. In my previous project (Chaplin, 2011), one participant with chromosomal variations additionally experienced comorbid mental health issues which impeded social functioning at familial and wider social network levels. This particular embodiment was bound in the biomedical discourse as a congenital condition that transcended the binary framework from within. According to WPATH (2011a, p. 72) "the gender-relevant medical histories of people with a DSD are often complex." Indeed, in this study, her diverse embodiment impacted upon physicality, psyche and social relations. Familial awareness of this embodied difference was a confounding factor at that time through non-acceptance and avoidance. This avoidance suggests the creation of aloneness; going through this journey of difference without acknowledgement of being while knowing that difference is your distinct reality. Being aware of this diverse reality as a teenager can also bring with it feelings of powerlessness, as indicated below by one participant:

> *…when I was 16, I felt really down. I felt like that if I didn't transition there and then I would probably kill myself. And I was really depressed when I found out that you had to be 18 at least to transition like without your parents' consent. It was just constant anxiety, depression. So I tried to talk to my mum about it but she didn't take it well and did a whole guilt trip on me. (Daniel, male, age 25)*

For this participant, the urgency of a male embodiment becomes intertwined in an imposed reality embedded in the legalities of minority and majority and traditional family structures that deny the existence of trans* as an alternative reality. Daniel's status as a minor is a barrier beyond his control. Daniel's urgency also aligns with Vitale's (2010) view of the waiting game and Langer's (2014) painful awakening because the time to change is out of reach. Everyday life; the "paramount reality" (Berger & Luckmann, 1966, p. 25) is caught up in this constant struggle between body and mind. It is this interplay between the physical and the psychological which potentially has the power to impede or empower the development of the self where identity is defined by time. For the following participant, it is the unknown and the confusion of conflating sexuality and gender that overwhelms daily existence:

> *I had severe depression when I was a teenager; severe depression…I tried to kill myself when I was 17. I was on anti-depressants; got out of that and then had a real bad drug problem; all sorts of things. I was just so self-deprecating my whole life and I could never pick what it was…you know I hated being a female but it was for a long time I thought all lesbians wanted to be men. Seriously I thought that was just part of being a lesbian. (LM, male, age 27)*

In the search of self, knowing that you are different but not knowing what you are can transport the psyche to a place of self-loathing and

personal worthlessness. This particular notion suggests that there is a tension in reorienting to a masculine embodiment within everyday life. Drawing on Devor (1997, p. 87), some trans* men such as LM are "initially attracted to lesbian identities on the basis of popular images of lesbians as mannish women." Once again, the physical and the psychological are entangled as the perception of experiencing one's body is blind to an alternative reality. The point is that the perception of something not fitting the physiological body schema overlaps with the psychological. In keeping with Merleau-Ponty (2012, p. 90), "…man is not a psyche joined to an organism, but rather this back-and-forth of existence that sometimes allows itself to exist as a body and sometimes carries itself into personal acts."

Everyday life takes a back seat for some and the ability to function socially diminishes:

> *I was really having a bad time with depression and suicidal thoughts and anxiety and all that kind of thing at this time and I just missed you know like weeks and weeks of Uni. I just didn't go in and didn't do any work. One of the days when I was just kind of sitting round doing nothing I started reading these magazines out of boredom and there was a story in one the magazines about a trans* man so it was somebody who had transitioned from being female and describing all these negative feelings like I'd been feeling and gone and made themselves a man. I was just shocked. I had no idea and I was seeing a doctor you know to get anti-depressants. (Robert, male, age 31)*

This "unknowing of me" can compound itself at a personal and social level and it affected daily life until there was a realisation of the possibility of an alternative reality that could and did make sense. Nonetheless, "knowing me" can equally lead to issues surrounding mental health, as the following account suggests:

> *I had a big sort of issue with depression from late 20s through to mid-30s so work was quite unstable and things and I felt I needed to get my mental health under control before I could transition. I look back now and think that was a mistake. I probably could have transitioned and that would have got my mental health under control. (Buffy Dunlop, female, age 44)*

Just as there are tensions around achieving masculine embodiment for trans* men and the unknowing surrounding those issues, tensions also exist as some trans* women such as Buffy acquire a feminine embodiment despite knowing that an alternative reality exists. These acts are played out at personal and social levels and the self-loathing and unsureness associated with first puberty can be reignited when the trans* person finally realises that there is a name for their condition – gender dysphoria. It is therefore unsurprising that two recent studies (Couch et al., 2007; McNeil et al., 2012) found that 125 (49.4%) and 549 (55%) of the participants had been diagnosed with depression previously and a further 293 (33%) participants believed they were depressed although undiagnosed (McNeil et al., 2012). Additionally, with respect to suicide attempts and suicide ideation, McNeil et al. (2012, p. 89) found that "the majority of participants, 84%, had thought about ending their lives at some point. 35% of participants overall had attempted suicide at least once and 25% had attempted suicide more than once." The findings of this study support the findings of Couch et al. (2007) and McNeil et al. (2012).

Part of the mental anguish experienced by some participants in personal identity development is not solely in terms of the existence or otherwise of psychiatric comorbidities or the self-loathing of that unruly body during first puberty. Feelings of low self-worth also awakens in some the

knowledge that they will be oppressed and ostracised as a social being and feel intense psychological shame as a personal being (Hill & Willoughby, 2005). Those aspects of the lived experience of some trans* people are explicitly linked to the objectives of this study. The following section contributes to the understanding of those experiences.

5.2.5 Passing and the fear of being me

On a personal level for the participants, there is need for acceptance, but this acceptance is embedded in our social worlds in our everyday interactions as a social animal. Identity development is not done in isolation as Berger and Luckmann (1966, p. 51) suggest when they state "man's self-production is always, and of necessity, a social enterprise." In the social world of the family, everyday life becomes an issue which lead to feelings of inadequacy and self-loathing, as the following participant account suggests:

> *My dad used to make me hide in my room if somebody came over. I think that's made me feel shameful to be trans* and like it's not normal and you know I'm not human. I'm just a monster... (Daniel, male, age 25)*

For Daniel, an abnormal sense of self is socially imposed at the familial level. He is classed as a biological abnormality that needs to be hidden from public gaze. As Canguilhem and Jaeger (1962, p. 28) suggest, the monster is nothing more than "a living being of negative value." Often, the secret is kept in the family (Zamboni, 2006). The concept of the monster has long been associated with the ambiguity of gender expression, much like the hermaphrodite in the 17th and 18th centuries (Foucault, 2003; Warren, 2014), or, indeed, in the present study, with one person possessing abnormal chromosomal variations (that is to say, abnormal from a biomedical

perspective). Pursuing this notion further, for Berger and Luckmann (1966, p. 169), this internalised transphobia can be viewed as the "individual's subjective self-apprehension" and is a concept directly attributable to their unsuccessful socialisation as a child that should remain in the private realm. Berger and Luckmann (1966) would have the monster in us to assume both a public and a private biography in our daily lives. This 'asymmetrical' approach suggests hiding the true self from public view and in itself becomes another form of social control. Nonetheless, the imposed internalisation of self-loathing was socially overturned by wider personal networks. This social overthrow of such archaic notions is further suggested by another participant:

> *We still lived; less so now than in a society that said if you're transgender or you're diverse or gay or lesbian, then you're somehow lesser, and part of that was myself putting it on me and part of it was my body. (John, male, age 34)*

These displays of self-apprehension that Berger and Luckmann (1966) espouse, by wanting to delineate public and private lives, go beyond self-doubt and unsuccessful socialisation. The transition process is, in itself, kairotic, much like a narrative. As argued by Ricoeur (1981b), there is a right time and a wrong time. All the participants in this study approached transition in their own time and place. Part of the process in searching for self and actualisation of the 'real me' is the assumption that trans* people occupy a space outside the heteronormative world based upon their embodied being. For John, the assigned feminine corporeality is embodying a masculine ideal for the reason that there is a knowing of trans*ness existing as an alternative reality to the heteronormative world.

> *I was running away from myself because I was so ashamed and guilty about what I felt inside and you know it's been a whole process about overcoming all that. I've been on this rollercoaster for many, many years. I've been arriving at this point and taking a detour. No matter what I did I always came back to the same place. (Ms Mel, female, age 50)*

The denial and subsequent self-approval is, in itself, a gradual process as Ms Mel's account suggests. Her decision to deny the inevitable transition delayed an appreciation of self and suggests the creation of unnecessary personal and social impediments. According to A. Singh, Hays, and Watson (2011) delaying transition relates to the fear of not passing as the intended gender or being understood as a trans* person based upon the binary notion of gender. From Goffman's (1963) viewpoint, the notion of 'passing' is in itself, a form of stigma, which may or may not be visible to the social world. Social persecution, fear of not passing and being misunderstood are indeed distinct realities, as suggested in the following account by the same participant:

> *You lived in the shadows and I didn't want to live in the shadows. I had to strip it all away and just let my real self-come out; to lighten up my load. I always felt guilty too for what I became because people used to say to me "Oh you're a good bloke." But you don't know me…you don't know who I am. How [are] you going to feel if you knew this about me? This is what I was thinking. That's why I could never come out. (Ms Mel, female, age 50)*

There was a fear of not being able to 'cut it' in the real world and to be subjected to social exclusion and derision. Not passing invokes in some a sense of deep personal shame and guilt. Peer pressure and wanting to fit in to a 'normal life' created a denial of self and suggests a sense of self-imposed punishment which lingered into the current context. Drawing on

Whittle (1999b), whether trans* people pass or not, they experience their body as shameful. As Whittle (1999b, p. 7) argues:

> …we [trans* people] have been programmed to pass and hence disappear. If we don't pass, we are for all time to be punished for our failure to become real. Either way we are meant to hang our heads in shame. Shame at our incurable madness, at having the blatant, unnatural greed to actually become the desired self.

The desired social acceptability and the shame in not passing embodied itself in an interplay that masculinised their identity. The temporal aspect of this social construction suggests that the time to change was dictated by an inability to change and the fear of discrimination. This finding is reflected by Couch et al. (2007, p. 70) who reported that "fear of discrimination prevented some participants from expressing themselves openly and caused them to postpone transitioning." According to Bockting (2008), this inability to change is encapsulated in the trans* person's perception of living outside the socially acceptable binary framework of gender and as a result, many deny the opportunity to explore their true selves for fear of social persecution. For the following participant, passing and misgendering[76] are also embodied in the perceptions and language of others during 'the change.'

> *I was kind of on the boundary of how people would read me. So by that I mean I was sort of 50% of the time being read as male and 50% of the time being read as female, and all my existing friends and family were still using female pronouns and it felt strange asking them to change even though I knew I had to do that so in some ways it was kind of good because I got to Sydney and people just read me as male. (Jeremy, trans* male, age 29)*

[76] A particular form of misgendering is referred to as mispronouning (Ansara & Hegarty, 2014) when incorrect pronouns are used to describe a trans* person.

Drawing upon McLemore (2015), misgendering is psychologically disruptive for trans* people, and affects the way trans* people view their personhood and their social identity. Ansara and Hegarty (2013) go further by arguing that misgendering is a form of social exclusion. Jeremy's account suggests a socially imposed denial of self through misgendering and the social network's inability to come to terms with that change by hanging on to the vestigial female embodiment of 'she' and 'her', reflecting the views of Ansara and Hegarty (2013) and McLemore (2015). The breaking away from a negative social and cultural context freed the embodiment and passing was no longer an issue. Another participant related similar concerns:

> *It was quite important to start with but I never got it so I just kind of gave up on them and they've kind of started using my name now. Even mum sometimes accidentally almost says it, but she never says Robert when she's thinking about it and she uses my old name a little bit like a weapon sometimes. (Robert, male, age 31)*

These accounts of participants experiencing internalised transphobia and the fear of not passing are consistent with the ideas of Singh et al. (2011), Hill and Willoughby (2005), Bockting (2008), McLemore (2015), Ansara and Hegarty (2013) and Mizock and Lewis (2008) where the development of their personal identities was questioned at both a personal and a social level. The self-loathing and the transcendence to an alternative reality are demonstrated in this participant produced image entitled *"Hope*."

Figure 4. "…how empty and hollow and pathetic and useless I was before I was able to really experience my transition. I had quite serious depression. I never liked myself. I always hated myself…and it's interesting how much that first operation; that one little thing…one operation that didn't actually change any of the way that my body functioned. It didn't make me a biologically born gendered man but it made me human. It made me real. I feel like I exist." (Robert, male, age 31)

Beyond the personal turmoils of growing up, self-realisation, issues surrounding mental health and self-acceptance, the journey towards the actualisation of being authentic lies in the physical transfiguration itself through hormonal therapy and surgery for those that pursue SRS as a valid outcome. As discussed previously, hormonal therapy and surgical options have long been considered successful outcomes for the majority of recipients (WPATH, 2011a) and therapeutic regimes are customised to individuals (Hembree et al., 2009). I now explore those hormonal and surgical personal developments as they apply to this study.

5.2.6 Second puberty: new forms of masculinity and femininity

Changing at the social level through name changing and 'living the dream' go some way to relieving dysphoria, but for those who pursue SRS, this social change is insufficient and dysphoria still exists. Body modification through hormonal and surgical interventions are signified as the 'second puberty' for trans* people who undergo these irreversible transfigurations. The first step beyond the social change in the transformation is generally conceived as the hormonal alignment to the preferred gender, as previously discussed.[77] The most important aspect of this transformation relates to the notion of the lived body – the body as experienced in tandem with the mind (Merleau-Ponty, 2012). The relationship between the mind and the body expands as the body and mind transcend natal physicality – the concept of marginality of the bodily experience also makes a transformation, as suggested by the following account:

> *When I approached (name of health service) they got me onto hormones very, very quickly. My anxiety really settled down after I started on hormones. I was very, very calm. (Ms Mel, female, age 50)*

The first signs of Ms Mel's contented embodiment appear as hormone therapy begins to alter physicality with 'second puberty' taking its course. The physical effects of this embodiment interplay with the innate psychological persona to contribute to this contented embodiment. Fundamental flesh (Ricoeur, 1992) alters the view of the world. Greater

[77] It should be noted here that none of the participants in this study were recipients of puberty blockers at 'first puberty' as this type of technology was not generally or widely available.

significance is given to the perceived embodiment, which is further noted by the following account:

> *I think the moment I got my first injection [testosterone] I was just so happy. I think the first change I noticed was sweating. I just started sweating from every pore in my body…and yeah I was becoming male. (Daniel, male, age 25)*

Drawing upon Canguilhem (1989, p. 144), this biological transformation renames what is normal as "it finds conditions of existence in which it will appear normative, that is, displacing all withered, obsolete and perhaps soon to be extinct forms" through creating a new normal that does not equate to a diseased disequilibrium. Indeed, nature through alteration in biological functions affected by hormonal therapy creates its own equilibrium. As the body begins to alter its biological functions normally associated with first puberty, thoughts of those signifiers of unwanted identity also dissipate as suggested below:

> *And also after testosterone, you stop having menstruation, you stop having all of the unpleasant hormonal reminders of…as one of my friends said "bad body things." (Jim, male, age 32)*

However, there comes a point in the transition trajectory for those of us who pursue SRS when hormones alone with their effects of changing voices, budding breasts, beard growth, enlarged clitorises, shrunken testes, changes in muscular tone and so on just aren't enough to relieve dysphoria. In contrast to the painful awakening (Langer, 2014) previously associated with first puberty, unwanted body parts remain as impediments to a contented embodiment. However, the surgery is a volatile moment in time as the physical baggage of a previous embodiment is discarded, as related in the

following image entitled *"Relief."* The image was produced by a participant as he reflected on his visions of surgery and the emotional effect on his body image.

Figure 5. "This is me looking in the mirror. It was mixed emotion, I was crying. This was afterwards and I was happy. I wanted to wear a singlet. It was my chosen outfit that would [make] me feel good after surgery. I remember standing in front of the mirror, put the singlet on and I was so overwhelmed with happiness but slash sadness. It was the first time that I could finally be upset for the 4 ½ years of binding." (Jimmy, male, age 33)

For Jimmy, there was an affirmation of being and years of searching for self finally dissipated. Jimmy's identity was attained through SRS by removing the female hallmarks known as breasts. Binding remains a physical and psychological burden for trans* men awaiting surgery with its constriction, extreme physical pain and social isolation (Nelson, Whallett, & McGregor, 2009); the signifier of womanhood which was a site of self-loathing during first puberty was replaced with a contented embodiment; the creation of a male chest freed not only Jimmy's body of the physical chains

imposed by binding but also the mind. To enhance this analysis of the chains that bind and the sense of self-actualisation, the following image, entitled *"1000kgs of Suffering Lifted,"* reflects that moment when the chains are removed.

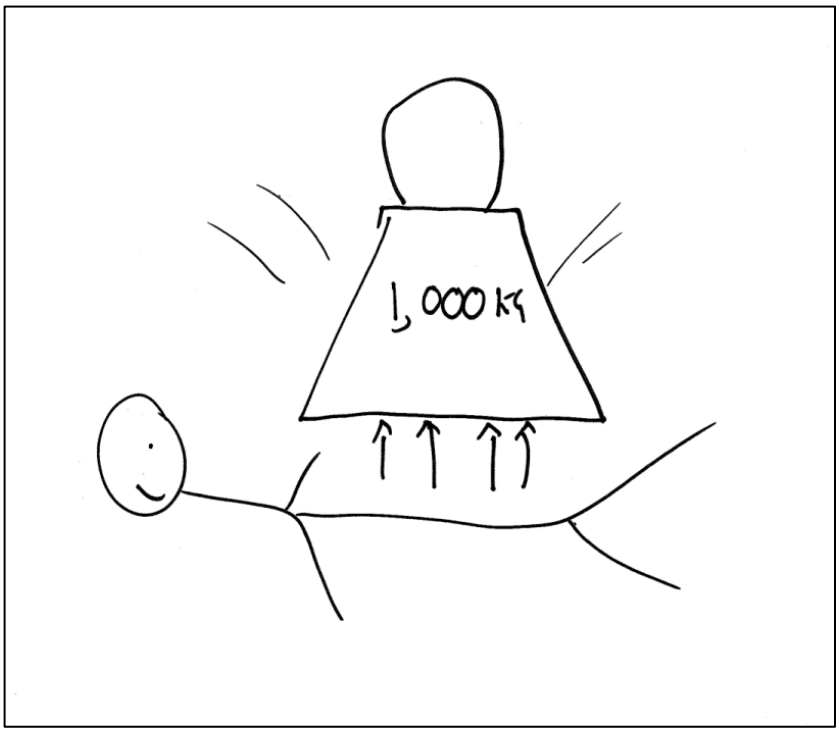

Figure 6. "It's a huge…a huge enormous weight both literally speaking but also emotionally – felt just very lifted. I have a quite vivid memory of waking up postoperatively and feeling uncomfortable but feeling this immense sense of peace really. It felt really good that transformation was perhaps even more profound than I anticipated in a positive way. There was this enormous weightlessness." (Jeremy, trans* male, age 29)

This notion converges with the findings of Nelson et al. (2009, p. 333) who reported that reduction mammoplasty allowed many (actual number not stated) of its trans* men recipients to lead a "full and normal life." This realignment of the corporeal and the psychological and a contented embodiment is further exemplified in the following account of surgical rebirth.

> *It was really overwhelming in a good way all because one little operation that didn't actually change anything about me. It just changed the way I thought about me. (Robert, male, age 31)*

Surgical rebirth is not simply a physical adornment. The surgical modification of *'dys-appropriate'* body parts goes beyond the physical perfection generally associated with body modifications and plastic surgery. According to Dozier (2005, p. 306), surgery for trans* men is about being comfortable in their bodies. It is also to ease the physical and psychological burden and the ability to create a visible sign of identity, as suggested below in the participant-produced image entitled *"Optimum Result."*

Figure 7. "Surgery to me was like the beginning of the rest of my life. I was about 5 months on T[estosterone], and…that was all good and well but I didn't really care until I had surgery. It's like when I think I found out I was having surgery, I started envisaging the end result of how I wanted to look." (Leroy, male, age 31)

As these participants' accounts suggest, hormonal therapies went some way in providing relief from dysphoria. Nonetheless, for the participants in this study, improvement in health and wellbeing can be directly linked to development of the self and the satisfaction of fulfilling personal and social

authenticity through a positive body image directly related to SRS. This finding is consistent with the findings of Couch et al. (2007, p. 70), who stated that "transitioning that involved hormone therapy or surgery…brought feelings of completeness, well-being, and satisfaction." SRS, although final and irreversible, brought about a sense of freedom – the freedom to pursue life as it was meant to be, and freedom from the corporeal baggage assigned at birth. Furthermore, the findings align with an American study (Davis & Colton, 2013), where the trans* men participants who surgically transitioned, surgery provided a protective factor against suicide. Finally, according to Boza and Nicholson Perry (2014), surgery is indicative of a decrease in depressive symptoms. Just as breasts and chests are the main incongruency for trans* men in their pursuit of a contented embodiment, penises and vaginas are at the forefront of the trans* woman's self-loathing and fulfilment in this study.

> *What this [surgery] was about was about me having congruency within myself and about not having to wake up every day feeling disgusted every time I had to go to the toilet or have a shower or get changed or having to deal with this thing that when I looked in the mirror… it set me free of all that. (Ms Mel, female, age 50)*

The constant reminders of an unwanted biology, deeply personal and unseen by others, are a confronting symbol of manhood relentlessly relived on a daily basis. The concept of the classical transsexual with the misalignment of physical versus psychological characteristics (Benjamin, 1966, p. 19) is exemplified as she "despises his sex organs," where feelings of gender expression are categorised as "high intensity." Surgical

realignment to the feminine self typifies freedom and body ownership of the innate identity, as the following image, *"Flying High"* demonstrates.

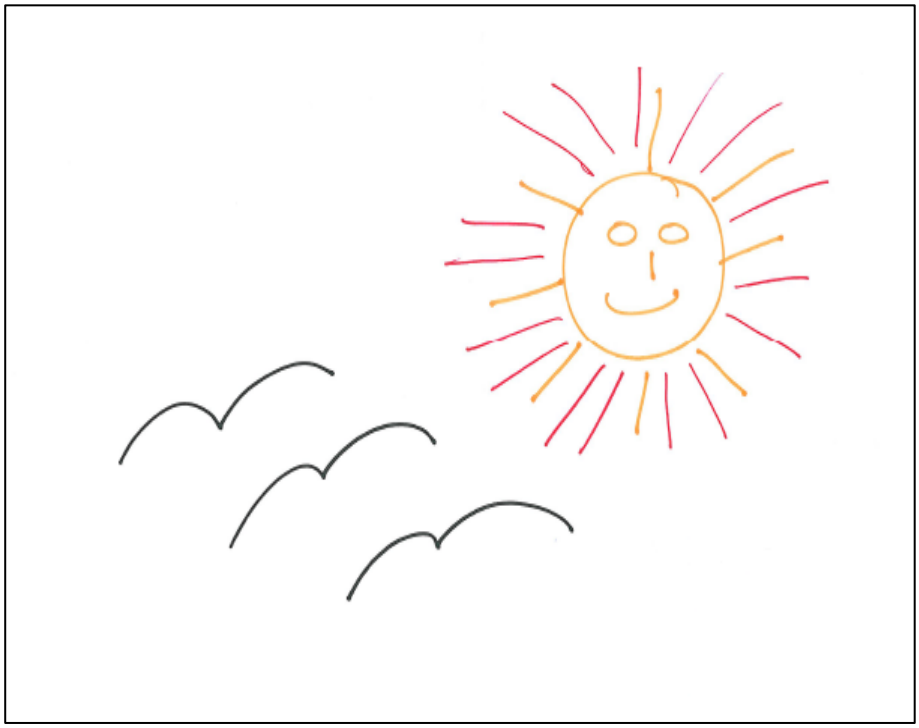

Figure 8. "I can see myself flying just like these birds. I am free at last to do what I want and be who I am and not worry about being this person that doesn't own themselves. You know, ownership of your own self is important and I now own myself; my body is the way it was meant to be. I'm like the sun itself…I'm radiant now. Yeah…and that's always stayed with [me] since the operation." (Dee Dee, trans* woman, age 49)

For Featherstone (1999), this ownership, control of self and the modification of bodily parts is a common thread and body modification is a visible testament to self-identity. However, transfiguration of the trans* body is more than an attempt to standardise the self along gendered lines. The very nature of the trans* body can be viewed as a "site of disruption" (Featherstone, 1999, p. 6) and can easily be regarded as a shared body, much like that of the conjoined twin (Shildrick, 1999). According to Shildrick (1999), the space occupied by such physical abnormalities defies normalisation. In contrast, for trans* people, I argue that the notion of a

shared body is more disparate than the closeness of the conjoined twin with its nuanced connotations of ‘the monster’ where stigma is always visible to the external world, ‘passing’ is denied and social identity is bound in one’s physical presentation (Goffman, 1963, p. 65).

This concept of a shared space finds its release by replacing one physicality with another, effectively setting free the psyche from that built up turmoil, as the following image entitled *“Awaken”* produced by one trans* woman suggests:

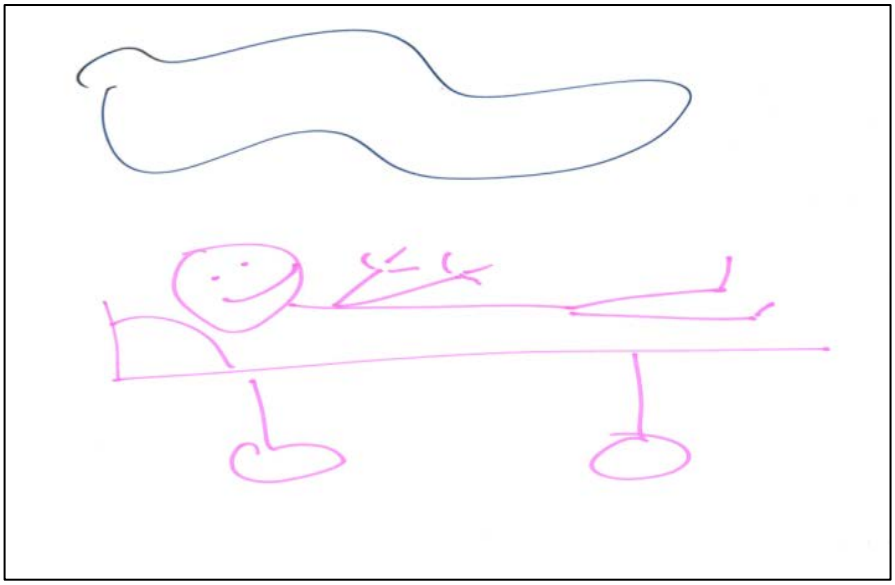

Figure 9. “One of the biggest moments was immediately after the operation and when I came to, there was this cloud. It was like matter and I felt it leave my body. It was like a spirit left my body.” (Phoenix, female, age 42)

For trans* people pursuing SRS such as Phoenix, there are perceptions of a temporal separation which may be characterised into ‘pre’ and ‘post’ surgical realignment, and these perceptions are played out into the activities of everyday life which are normative, not normalised. As Canguilhem (1989, p. 200) argues, “man feels in good health - which is health itself - only when

he feels more than normal - that is, adapted to the environment and its demands - but normative, capable of following new norms of life." This pre/post transformation and its normative outcomes are succinctly displayed in the following image entitled "*Big Improvements."*

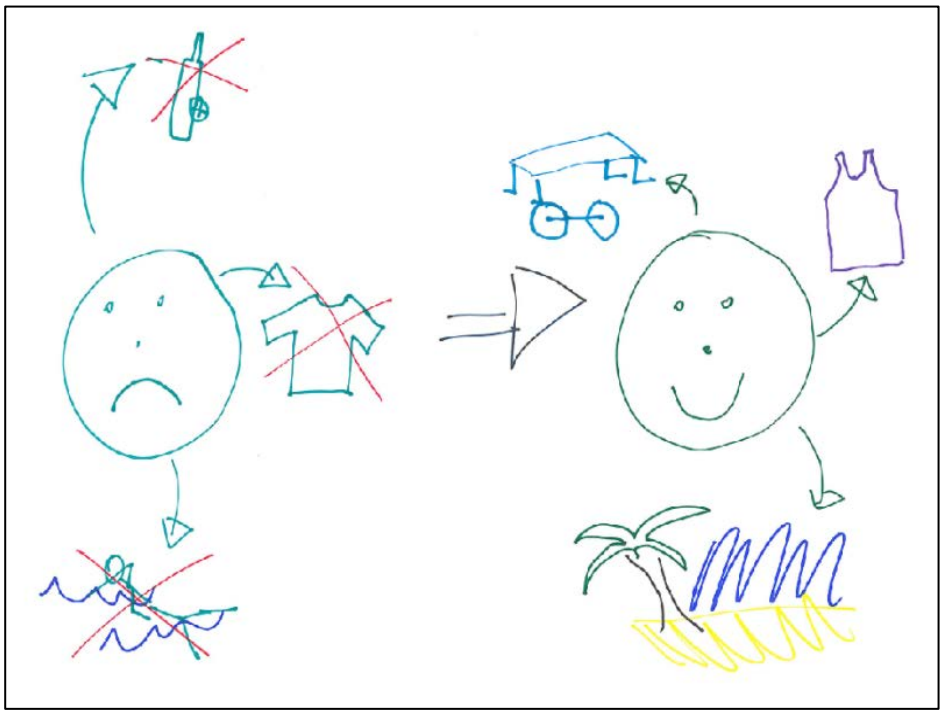

Figure 10. "[Before] it's representing the things that I couldn't do that are part of the way I see myself so I couldn't really play sport; I couldn't really go swimming and I couldn't wear a t-shirt or clothes and overall that sort of impacted on my ability to relate to my friends and you know live my life the way I wanted to live it. [After] it's all the things I could start doing again that made me a happy person so I could go to the beach, I could wear tight clothing, I could go to the gym and all of those things made me feel happier and more confident and more able to participate in life generally." (Jim, male, age 32)

For all the participants in this study, SRS improved personal perceptions of the self corporeally and psychologically, by replacing what society views as a diseased embodiment with the realisation of authenticity. In the words of Canguilhem (2000, pp. 351-352), "health is more than normality; in simple terms, it is normativity…any normality open to possible future correction is authentic normativity, or health."

5.2.7 Dysphoria revisited: trans* man's body 'works in progress'

Nonetheless, the transfiguration process of those unruly trans* bodies provides different realities; a positive euphoric reality and an equally negative dysphoric reality. That is not to say those negative realities were characterised by regret but were merely body 'works in progress.' SRS provided improvement in the participants' quality of life and sense of self, although for some of the trans* men in this study, a genuine dysphoria still existed due to the complexity of the surgical process itself and the corporeal remnants of the female form and those vestigial organs. These can be interpreted as impediments to personal self-hood. Ruly tops and unruly bottoms create a personal confusion as the following accounts relate:

> *Lower dysphoria is my main thing because it's the main incongruity when you look at yourself in the mirror; it just doesn't make sense to me and I assume to my partners but they make sense of it in a way that I don't understand. Yeah, it's just the missing link; it's just a strange state to be in. (Jimmy, male, age 33)*

For Jimmy, the perception of owning a male embodiment with a male chest is mismatched with seeing the vestiges of the female form, and is further complicated by the perception of the body in social and intimate relationships. The acceptance of the mismatched form by partners creates a further confusion at the personal level. This dysphoric confusion is supported by the findings of Williams et al. (2013, p. 730). In their study on the sexuality of trans* men, similar confusions were evident in that "sexual partners were often involved in the validation of the trans men's gender identity." On the other hand, T. Jones et al. (2015) reported that some participants were unconcerned with this visual mismatch, either personally or intimately. This mismatched visualisation is taken a step further when

biological functions associated with the female form, not subdued by testosterone, come into focus and the need to come to terms with the reality of an unruly physicality.

> *I'm very dysphoric down there. The rest of me I'm fine but that's still a big barrier and I thought for a while it was like "no you've just got to accept it." The thing I have the biggest issue with and I even hate saying it…it's the wet. I don't actually have an issue with my trans* cock. I'm cool with that but it's what's happening underneath, so if I had a metoidioplasty*[78] *that would just eliminate that. (LM, male, age 27)*

The constant reminder of the female bodied man similarly converges with Williams et al. (2013), where 'wetness' is disassociated from a male sexual embodiment and is a source of continued dysphoria. Similarly, for K. Johnson (2007, p. 55), this 'wetness' is a "marker of a previous embodied being." On other matters sexual, one participant noted that masturbation was a source of confusion and brought back vivid memories of a female embodiment:

> *…masturbation. Afterwards I feel my body's female again. I feel the curves are bigger and the boobs are coming back; my hands are smaller, my feet are smaller; my voice is getting higher. The clitoris sort of acts likes a penis so I'm happy with that, but the ending, the orgasm; it's still a female orgasm. (Daniel, male, age 25)*

Contextually, this perception of orgasmic experience diverges from findings of Williams et al. (2013) where some of the trans* men participants spoke of the maleness of their orgasms both in urgency and intensity, in line with stereotypes of heteronormative masculinity and the orgasm (Snell, Hawkins, & Belk, 1988). This perception also diverges from the findings of

[78] Metoidioplasty is defined as a clitoral extension.

Jokić-Begić, Korajlija, and Jurin (2014) where all three of the FTM participants reported sexual satisfaction with masturbation. However, it is not just those anatomical sexual attributes of the female form that cause dysphoria to postoperative trans* men. In this study, other non-sexual remnants of the female form were cause for concern, as the following accounts relate:

> *I have a lot of dysphoria I guess around my height as well. And biological males are usually taller than me and it's annoying. Like I know it's their life but I wish I had that you know. (Daniel, male, age 25)*

Height is viewed as a "hormonally unresponsive characteristic" in the adult population (Fleming et al., 1982, p. 462) and being tall is a typical, although not generalisable masculine embodiment. The perception of height as a signifier of masculinity creates a sense of dysphoria when you perceive your female shortness in relation to your social world, and can be interpreted as a visible signifier of 'not passing.' Other secondary gendered characteristics are also the site of disapproval, as related by one participant:

> *I'm more dysphoric about my hips than not having a penis. I'm even more dysphoric than I was about my chest. At one point I thought I'm not going to transition because of my hips. Honestly, I'll never pass. I'll never look like a guy walking down the street. (Leroy, male, age 31)*

Leroy's perception of the curviness of his female form as a permanent fixture in the body schema is another concealable impediment in today's social milieu. Masculinity, and femininity for that matter, are what we construct them to be as embodied extensions of our personhood. Drawing on J. Green (2013, p. 454):

> What makes a man a man? His penis? His beard? His receding hairline? His lack of breasts? His sense of himself as a man? Some men have no beard, some have no penis, some never lose their hair, some have breasts. All have a sense of themselves as men.

Green's (2013) words above clearly demonstrate the multiple realities of gender. Therefore, gender can neither be natural nor universally true (Zimman, 2014). When you are man with a vagina, the patriarchal, cultural stereotypes of manhood give way to the subtleties of embodying masculinity as "more nuanced" (Williams et al., 2013, p. 737), or as Whittle (1999a, p. 16) refers to as "a different kind of man." These nuanced differences are suggested by one trans* man:

> *That version of masculinity wasn't my version of masculinity. The trans* role models I had as a teenager was a very 'blokey' trans* man who was quite misogynist and kind of embraced all these things about masculinity in Australia that I hated, so then I really started to question would I be that then? I realised that there is a plural[ity] of masculinities and also not contingent on the body and that there was other ways to be who I was. (Jeremy, trans* male, age 29)*

In conclusion, for trans* men in this study, dysphoria re-enabled itself following various surgical procedures. The accounts of the participants suggest that there is still a mismatch between corporeality and the psychological based upon their unruly bodies. This notion is supported by the feminist views of Butler (1990), who argues that there is a pretence associated with those missing body parts that involves a bodily imagination. However, body works-in-progress, as suggested by Jeremy, engaged new form of masculinity not associated with the traditional gendered stereotypes of being a man. As Dozier (2005, p. 299) suggests, "[n]ot all men, constructed or biological, are masculine or wish to be."

This section has discussed the development of the personal self. I argued that the development of the personal self is staged and that the surgical process is one that has its genesis in the innocence of childhood. The rite of passage can be characterised by tensions around sexuality, body image, issues concerned with mental health and the ways in which society constructs gender. Social constructions around gender with notions of male and female, and what it means to be masculine or feminine impact upon trans* people resulting in stigma, discrimination and social exclusion. For some participants in this study, the tensions associated with self-loathing were internalised. They viewed themselves just as society does; unworthy and abnormal. There was a realisation that physicality is diametrically opposed to how the world is viewed and personal identity can be encapsulated as a personal and social stigma. Arriving at the point of self-acceptance comes with it a realisation that moving forward involves the modification of body parts which are the site of self-loathing and disruption.

Interestingly, modifying offending body parts not only relieved dysphoria but also ignited another Pandora's Box of gender related dysphoria for some participants in this study. The incomplete body works experienced by some trans* men re-establish a femaleness that they know is inherently not a part of their psychological world. This particular aspect poses an interesting juxtaposition with the trans* women who in their earlier childhood days remained steadfast in their male embodiments or avoided their feminine side altogether. However, I would argue that the completeness and relative simplicity of vaginoplasty as a surgical procedure removes those traces/markers of the masculine embodiment of childhood.

Therefore, I would conclude that perceptions of a female or male embodiment are an expression of unique bodily experiences. All participants' accounts suggest that from an individual perspective, surgery as an act met their needs. New forms of masculinity and femininity were created and became normative. As informed by Merleau-Ponty (2012, p. 93, emphasis in original), "it [the body] remains on the margins of all my perceptions, and that it is *with* me." The participants in this study drew upon their memories (the margins) of past and present embodiments, and in doing so, affected everyday experience of their embodiments. Finally, drawing upon Ricoeur (1992, p. 319), "one's own body is the very place…of this belonging, thanks to which the self can place its mark on those events that are its actions." Nonetheless, this personal identity development is not done in isolation, but is a discourse in the social world, as evidenced by the preceding discussion. Indeed, it is constructed socially and in the following section, I further explore experiences of the social self.

5.3 NAVIGATING THE SOCIAL SELF

While navigating the personal self through its exploration of the interplay between the physical and the psychological presents its own unique challenges to trans* people, navigating the social self presents its own challenges. As opposed to the development of the personal identity, which I argued was the product of reclaiming the gender we already embodied at that deeply personal level (albeit amid a social context), the social self is embodied in our interactions with the social world as one of the actors in that context. For the trans* people in this study, interacting at a social level brings

with it issues surrounding the reactions of family and other personal support networks. There is the coming to terms with going against the traditional heteronormative family values by deviating from that social norm of remaining in the gender assigned at birth. Additionally, there are tensions related to religious and spiritual beliefs, and these tensions make it difficult to fit in with traditional family beliefs.

For Berger and Luckmann (1966) the 'self' is formed not only through a dynamic, ongoing, physical development (which by its very nature must be an individual journey), but also through our interactions at a social level with those individuals who are situated in our environment. As Berger and Luckmann (1966, p. 51, emphasis in original) assert:

> Men *together* produce a human environment, with the totality of its socio-cultural and psychological formations. None of these formations may be understood as products of man's biological constitution, which, as indicated, provides only the outer limits of human productive activity.

According to WPATH (2011a, p. 29), the social aspects of finding an acceptable and authentic gender role may indeed be more challenging than the physical aspects of transitioning to that role. All the participants in this study underwent some form of SRS (vaginoplasties for the trans* women and a combination of mastectomies/hysterectomies for the trans* men). For trans* women undergoing vaginoplasty, an integral component of arriving at those irreversible interventions is living socially and "continuously for at least 12 months in the gender role that is congruent with their gender identity" (WPATH, 2011a, p. 21). For trans* men undergoing chest surgeries, WPATH (2011a, p. 21) recommends an "ample time of living in the desired

gender role and after one year of testosterone treatment." Although there is a variation in the approach for trans* women and trans* men, the overarching framework refers to the social adjustment to the desired gender role, and this is also a role that has its beginnings in childhood as it was argued in the development of the personal self. At the inner circle of the social world is the trans* person's family, a topic repeatedly referred to by the participants.

5.3.1 Defusing familial traditions

Tensions associated with what could be referred to as childhood play (dressing up, role playing and the like) may become socially unacceptable as young boys and girls explore those roles that ignore the cultural stereotypes of being heteronormative boys and girls. The way in which parents and siblings react to this behaviour may impact the social development of the evolving trans* identity, as the following account relates:

> *As a child I used to try my dad's ties. I used to put toothpaste on my face and pretend to shave as a five year old. I did lots of things everyone thought I would grow out of and then it got to this very awkward stage where I couldn't…it wasn't cute anymore to be a tomboy – it was actually socially awkward for everyone involved; myself and my friends, my parents and I hated any kind of formal event. I didn't want to be a girl in a tuxedo at my school formal. (Jeremy, trans* male, age 29)*

This type of behavioural modification for the gender diverse 'girl' converges with the views of Vitale (2010) who argues that there are minimal reprisals for acting out being male. According to Vitale (2010, p. 23), little girls personifying boyhood are constituted as "cute and the behaviour is usually tolerated by friends, family and school officials." This view consolidates my previous argument about the social construction of masculinity, which are historically and culturally situated and male dominance

is a socially accepted practice, although open to challenge, as Connell and Messerschmidt (2005) suggest. Familial knowledge of gender non-conformity can take various trajectories along the continuum from non-acceptance to acceptance. This notion of knowledge acquisition and its association with the acceptance/non-acceptance continuum can be illustrated by the following participant's account:

> *Dad for a long time said that he didn't know enough about it and because he didn't know enough about it he was just going to reserve judgement on that and that would be all fine and then I thought 'well you know fair enough because not everyone is an expert on the nuances of gender.' And so fine if you're not prepared to make a decision one way or another, at least you're being supportive of me and then at some point several years ago he said "well I've changed my mind. I've come to a decision. I've decided that I don't agree with your decision." And this would have been after 5 or 6 years of transition or something. (Robert, male, age 31)*

In an American study (Kuvalanka, Weiner, & Mahan, 2014) which aimed to identify how parents navigate their children's' transitions in a group of five MTF children ranging in age from 8-11, two of the children had transitioned as early as the age of seven. In that study, Kuvalanka et al. (2014) found that the experiences in relation to the acceptance or otherwise by the parents for the expressions of gender nonconformity included such notions as assuming that their child was gay, or that it was "just a phase" (p. 13), to total non-acceptance by one of the fathers. Furthermore, Kuvalanka et al. (2014) described how fathers generally struggled in coming to terms with the concept of gender nonconformity based upon such notions as fatherly responsibilities and lack of knowledge. This lack of knowledge of "the nuances of gender" as described by the participant, Robert and the

possibility of the notion of a transient phase are consistent with the findings of Kuvalanka et al. (2014).

The reversal of previous supportive acceptance is indicative of the overwhelming grief and self-doubt (Kuvalanka et al., 2014) some parents face which may not necessarily be distinct processes, but what Emerson and Rosenfeld (1996, p. 4) describe as "overlapping, nondiscrete stages, depending on their relationship with the transgender individual." Additionally, according to Emerson and Rosenfeld (1996), the traditional beliefs of parents and families become interwoven in the acceptance process as the following account illustrates:

> *I was on hormones and cutting my hair was a big deal because of my religion I am not supposed to cut my hair. As a Sikh, you're supposed to have long hair and not cut it and wear a turban for men and for women, it's optional but you still don't cut your hair. So that was a massive struggle so I wasn't allowed to be myself because of that or because of my parents' narrow-mindedness. (Daniel, male, age 25)*

Symbolic religious rituals such as uncut hair become problematic in religiously conservative families (Oswald, 2001). For Oswald (2001, p. 45), who conducted a study on the religious experiences of 45 LGBT people (four of whom identified as trans* people) surrounding the concept of religious rituals found that those individuals who were raised under religious conservatism saw themselves as family outsiders and "perceived themselves as outside the ritual." My study supports those findings. The notion of being the outsider is further suggested by one participant whose parents' views on sex/gender were based upon the scriptures:

> *I mean they say that it's in the bible but it's not in the bible. There's nothing about gender or gender variance in the bible. They only use the New Testament as Baptists [and it] would be that thing in Romans*

> *and Timothy and Corinthians about homosexuality but because they think I'm gay because I was born female and I like women, but I'm not gay. They don't recognise the gender thing and so they still think of me as a woman so they think that I'm gay because I like women and they think that's wrong because the bible says homosexuality is wrong. (Robert, male, age 31)*

According to Witten et al. (2004), there is little support for transsexualism across the Judeo-Christian-Islamic religious spectrum to the extent that being transsexual is stigmatised. Furthermore, the conflation of homosexuality and transsexuality is a common thread amongst some theologians (Childs, 2009). According to Childs (2009), the theological debate on these issues leaves little doubt that the impact of religious attitudes concerning trans* people is yet another form of social exclusion. Thus, it is no wonder that Robert and Daniel see themselves as outsiders. On the other hand, some trans* people find comfort in linking to spirituality as opposed to religion as the following account relates:

> *I had also had a lot of conflict with surgery and I wasn't sure whether that was the right path to go down, and a friend of mine [friend's name] she turned around to me and said, "Everything is created by God, so surgeons are created by God, and surgery is created by God, and if this a tool you want to utilise, go for it." And that advice from her really changed my perspective as well. It resolved a lot of issues. (Phoenix, female, age 42)*

The notion of divine intervention into transition is evident in some small pockets of religious faith. Speaking on the unity of body and soul, Watts (as cited in Childs, 2009, p. 38) asks the question "Must we not be grateful that modern science has made it possible?" This view is in stark contradiction to the views of Pope Benedict XVI (as cited in Religion Dispatches, 2009, September 2, para.15), who espoused in an article on trans* people that "it is

a question here of faith in the Creator and of listening to the language of creation…the devaluation of which leads to the self-destruction of man and therefore to the destruction of the same work of God." Nevertheless, family support or lack of it goes beyond those traditional beliefs or being a trans* person when the functionality of the family temporally and spatially projects the individual into social isolation:

> *Family support is so important. I don't have it you know…my parents lied to me…there was that much fighting and domestic abuse; fighting over money and all sorts of other issues, instead of appreciating the real values of life. I haven't lived at home since I was 16! I haven't lived at home since I was 16, so I had to fight for my independence early in life but still having no family. (Ms Mel, female, age 50)*

Although this participant's rejection by family is not explicitly associated with being a trans* person, it highlights the importance of support at the familial level (Tew et al., 2012). Issues surrounding social isolation directly associated with being a trans* person are described by one participant:

> *Well my mother is dead and my father's estranged. I lost my family. They didn't want to know me basically. My sister is still estranged. My two brothers…my younger brother just cried and cried when I told him but then he's psychologically unstable. It isn't fair. This was supportive in a way. And my older brother just didn't know what to do; he had never heard of it either and asked me not to see any of his children or family. His wife [said] to just stay away until he worked it out. Now he has worked it out so kind of in one way I look at it as a fair request but I lost all support. I lost all support. There wasn't any. I had one friend in the whole world because I'd gone into isolation to cope with my body being female. I'd stop[ped] socialising long ago. (Andrew E, male, age 48)*

The importance of family connectedness and its association to mental health outcomes is well documented in the social science and social work literature, significantly so for the trans* community (Lev, 2006; A. A. Singh, Meng, & Hansen, 2014; Tew et al., 2012; Trevor & Boddy, 2013). According

to Trevor and Boddy (2013, p. 559), “transgender people are subject to pervasive negative psychosocial consequences from family, friends, and the broader community,” including issues such as social isolation and harassment. In their study on resilience strategies for trans* youth, A. A. Singh et al. (2014) found that supportive families developed resilience. This particular aspect also aligns with the findings of Levitt and Ippolito (2014) in their grounded theory study of 17 self-identified trans* people concerning identity development. Levitt and Ippolito (2014), found that positive social support built self-esteem and gave the participants in their study the strength to explore their various identities. Conversely, A. A. Singh et al. (2014), found resilience was threatened when the participants in that study were emotionally and socially isolated from family and friends. The participants in this study raised the importance of social supports as they relate to the surgical process.

5.3.2 Being (dys)connected

The importance of social support during any trans* related surgery is a paramount consideration (Couch et al., 2007). Friends and the wider social networks, but more importantly, family members, according to Lev (2006, p. 269) “are often unwilling participants on this journey.” The participants in this study experienced varying degrees of acceptance/non acceptance during their transition, whether that be mastectomy[79] for the trans* men or vaginoplasty for the trans* women. The family’s social adjustment to a dynamic embodiment through surgical transition can invoke feelings of loss

[79] I refer to mastectomy here as it is considered the most important surgery for trans* men to present socially, which aligns with the finding of T. Jones et al. (2015, p. 47), where participants expressed “that top surgery and other forms of masculinisation were more important to them.”

and grief, as family members and the participants come to terms with their new embodiment. A balanced approach to transition and the surgery was perceived as positive, as demonstrated in the following participant's account:

> *But I think on some level, being slow [the physical transition] was also good for my family, it was good for my partner. We could all just adjust incrementally to the changes rather than suddenly just be this guy – like overnight…and it also meant that those social adjustments were slower as well and I kind of started to learn how they worked. (Jeremy, trans* male, age 29)*

This participant's experiences reflects sound social work practice as described by Lev (2006). According to Lev (2006), the balanced approach allows acceptance and support to grow and evolve through the transition process. For Jeremy, mutual respect and dignity is maintained and allows the normal range of emotions for the family circle to take place over a period of time. From a social constructionist viewpoint, the family unit is going through a process of resocialisation (C. Whitley, 2013) to an alternative gender role. However, for Berger and Luckmann (1966, p. 171), this resocialisation is typically referring to the trans* person's unsuccessful socialisation and the "individual choice between discrepant realities and identities." Some participants found that they felt fully supported by family, partners, friends and the wider social network, as related below:

> *I pulled myself through it with the reverend, my daughters and lady friends and a couple of very nice guys as well and this is the thing. My main support came from friends after I came home and my daughter and having someone to look after and care for and that was reciprocated by (dog's name), my dog. (Irish, female, age 78)*

For this participant, support was forthcoming spiritually and from family and personal networks. For another trans* woman participant, support was offered by her wife and nursing staff:

> *It was good my wife was there. She has always been my tower of strength. My wife was with me most of the time. I had a private room and she was able to stay with me. The nurse said it was okay, so they got a camp bed type thing for her. I thought that was nice. (Dee Dee, trans* woman, age 49)*

From another participant, support was not only associated with his family, friends and partner, but extended to his employer as well:

> *My employer was really supportive and organised a lovely card like as if it were any other medical process and they were all keen to understand that I was safe and well and it was a successful surgery and I felt really well supported socially and emotionally by my friends and family and partner at the time. (Jeremy, trans* male, age 29)*

Another participant found support through a community group:

> *Yes I do have some trans* friends. There's a monthly support group at the [name of group] that I go to and that's really helped me. (Daniel, male, age 25)*

These findings are supported by a recent Croatian study (Jokić-Begić et al., 2014) on the psychosocial adjustment to SRS of six trans* people (three FTM and three MTF) who had all undergone SRS in Croatia over the preceding 15 years. Jokić-Begić et al. (2014, p. 7) found that the main sources of social support were "family, friends, colleagues and other TS[80] individuals." Acceptance and non-judgemental attitudes by the wider social network were perceived as positive social experiences, supporting the

[80] TS is an abbreviation of transsexual.

findings of T. Jones et al. (2015) in their study of 273 FtM transgender people. These participants in my study found emotional and instrumental support, and this research suggests that obtaining support had a positive effect on their health and wellbeing at the time. From another perspective, emotional support can waver beyond the surgical transition, as noted by one participant:

> *I wanted my friends and family around because it was such a personal and emotional issue for me that you know. Mum and dad desperately wanted to drive me into hospital. Significantly I had the most appalling argument with mum and dad only a couple of months ago [following surgery]…mum said that she'd hoped that she was dead before I'd have surgery and things like this. (Buffy Dunlop, female, age 44)*

As suggested by Lev (2006), post-surgery is a difficult time for families and the stages of acceptance are predictable, but rarely linear in approach. The grief of this mother losing her son to become her daughter is probably bound with the finality of the surgical process, the inability to come to terms with the paradigm shift from one gender to another, the self-doubt of being a good parent and its implications in the wider social network. These aspects have been highlighted in case studies (Emerson & Rosenfeld, 1996; Lesser, 1999) of mothers going through the mourning process. As noted earlier, it is not uncommon for the adjustment of family members to transcend several overlapping stages of acceptance (Emerson & Rosenfeld, 1996).

These findings are supported by an American study by Koken, Bimbi, and Parsons (2009), who described the experiences of twenty trans* women in terms of familial acceptance, where there was great variation in the perceived levels of support and acceptance, from malevolence to

unconditional support. Similarly, T. Jones et al. (2015) found that when relationships were difficult, levels of trust diminished while positive relationships improved happiness. Support can also be a reciprocal arrangement, where the trans* person supports their family through the surgical process. This perception of transferred support to family members as they experience loss and grief is another reality, as explained by the following participant:

> *I had extreme dysphoria with that part of my body. I don't love that word but it's true…um…and so for me, yeah I guess I…despite that maybe I'll feel loss. It's part of me, and part of my story…if anything I think the slight sense of loss I anticipated but didn't actually feel, was about how my mum and my partner were going to feel, and therefore maybe a bit of transferred loss, if that makes sense – like feeling grief on behalf of other people as opposed to my own grief. (Jeremy, trans* male, age 29)*

This support is rooted in private feelings (Rosenblatt, 1988). As suggested by Rosenblatt (1988), knowledge of an impending loss provides an appreciation of the feelings and emotions likely to be encountered socially following the 'final cut,' defined as the loss. This participant provided a supportive bridge to his family and partner that allowed a grieving process to take place. Another participant reflected on the concept of loss and grief, as the following account relates:

> *But that's funny, you know, when I went back to work, one of the girls in the office said "You've just gone through traumatic surgery having a part of your body literally removed." She wasn't being nasty or anything, and she was right. It's then I began to think it's like when someone dies, you mourn for that person. Maybe I was mourning for my old self. I know my wife mourned for losing me, but she didn't let on but I could tell. (Dee Dee, trans* woman, age 49)*

The loss of a loved one through death is final and a catalyst for grief and mourning. However, the death for Dee Dee is of her former self and her grief is shared by a married couple. There exists the loss of a spouse and the loss of an organ, where a sanctified relationship comes under scrutiny. For Dee Dee and her wife, the former relationship becomes an emerging new partnership. According to Israel (2004), their marriage often brings the couple closer together and the shared losses are anticipatory. Nonetheless, anticipating the removal of unwanted, functioning organs may create uncertainty and non-acceptance in the realm of sexual intimacy. As Israel (2004) notes, sexual relationships need to be renegotiated for the enduring couple. In conclusion, some participants in this study found support on many levels through their social networks, while others found support elusive. For others, it remains 'works in progress.'

5.3.3 Keeping secrets

In previous discussion (Section 5.2.5), I introduced the notion of family secrecy in relation to the 'biological atrocity' of being trans* (Zamboni, 2006), where families consciously conspire to hide the offending beast from view. Some participants in this study experienced secrecy through their transition. For one participant, this secrecy is concerned with perceptions of family acceptance concerning surgery, as suggested by the following participant's account:

> *They [mum and dad] knew I'd transitioned but they didn't take it very well. So I hadn't really seen an awful lot of them since I came out to them in 2004, when I was in Victoria. They were overseas for a year for work purposes. So I didn't really see them for a whole year. I'd sort of seen them on and off, but I actually hadn't told them I was having surgery. I still actually haven't discussed it with them but it's pretty obvious that I've had it. (Jim, male, age 32)*

The rejection of coming out at the familial level at first transition for this participant resulted in avoidance of the topic based upon non-acceptance, stigmatisation and lack of understanding (Lerner, 1993) of such a socially taboo topic (Vangelisti, 1994). For Zamboni (2006), the shame, embarrassment and social stigma of 'rearing' an abnormality challenges family identity. Theories on secrecy include such notions as disempowerment (Lerner, 1993) and social cohesiveness (Goffman, 1963). Social cohesiveness refers to the notion that the secret has a binding effect on those that know the secret.

The notion of secrecy is a common thread for transgenderism (Lev, 2006) and is bound in complex motives. Secrecy is known to have several motives including avoiding punishment (Lerner, 1993), confusion about the timing of disclosure (Imber-Black, 1998) and self-protection (Lerner, 1993; Lev, 2006). According to Wegner and Lane (1995, p. 26), secrecy is concerned with the "social consequences of disclosure." Time and distance affected social relationships for Jim, suggesting social indiscretion and social unacceptability (Vangelisti, 1994).

As Goffman (1963) argued, by creating and enduring a physical separation, individuals can mask their identity. However, despite the verbal non-disclosure of surgery, Jim's corporeal body language became a voluntary disclosure of the secret "thereby transforming his situation from that of an individual with information to manage to that of an individual with uneasy social situations to manage" (Goffman, 1963, p. 123). Another participant noted that keeping the secret from the wider social network was an unnecessary impediment to social acceptance:

> *The whole cultural aspect [being from Sikh traditions] is there as well because with my parents, they didn't…my dad didn't want to tell anyone about it, like it was a hush, hush thing. Like people would talk about it and it's a bad thing. But when we did tell people, everyone was cool. (Daniel, male, age 25)*

The premise behind this secret is the cultural integrity of the family structure, reiterating the taboo topic (Vangelisti, 1994), resulting in the participant's family taking ownership of the secret (Imber-Black, 1998). However, by withholding the secret from wider social networks, the transphobic nature of the relationship and the possible social stigma in revealing the secret were reignited. There is an interesting juxtaposition with the relationship from a heteronormative perspective. The social construction of gender is bound in those attributes of masculinity and femininity based upon a binary framework of gender. A review of the literature into the distinctness of relationships between fathers-daughters and fathers-sons (Russell & Saebel, 1997) suggests father-son relationships are bound in power and "masculinity and its development" (p. 119), and father-daughter relationships appear distinct across several dimensions including loving, working and the "sense of distance and difference" (p. 118). A father coming to terms with the paradigm shift of losing a daughter and gaining a son suggests a contradiction in cultural identities, which becomes disempowering for the social group (Lerner, 1993).

Based upon the participants' accounts, I would argue that keeping secrets, regardless of ownership of the secret, can result in psychosocial burdens for some trans* people, and thus impede personal and social development. How trans* people and their social world negotiate acceptance

of SRS as an outcome of trans*ness can impact upon self-image and social inclusion. In conclusion, despite a lack of social understanding and acceptance experienced by some participants, the findings of this study suggest that transitioning was successful from a personal perspective.

5.4 SUMMARY AND CONCLUSION

This chapter explored negotiating the SRS experience in relation to the personal and social selves. The participants' narratives were explored from a whole of life perspective, where the recognition of difference was apparent in childhood and played out along gendered lines throughout childhood and first puberty. Childhood play innocently shaped the future. There was significant confusion surrounding body image with its unwanted masculinity and femininity which contributed to sexual confusion and emotional uncertainty for some participants. These confused sexualities increased the psychosocial burden of some participants as they attempted to come to terms with their changing bodies. The tensions experienced expressed themselves mentally and emotionally where some participants internalised their self-loathing during a time of extended waiting; waiting to claim/reclaim something that existed all along, but was temporally out of reach. However, all the participants experienced a decrease in psychosocial burden at second puberty through hormonal and surgical regimes. SRS provided significant relief from gender dysphoria, while for some trans* men, a certain level of dysphoria remained due to the complexity of the surgical process; what I referred to as 'works-in-progress'. The body as it is experienced (Merleau-Ponty, 2012) by the participants demonstrates the unique ways in which trans* embodiment is situated. Each of these explorations further

demonstrates the complexity of being trans* and that trans* bodies challenge the social construction of gender with its normative views of male and female.

The social self explored the participants' interactions with their social world in terms of spiritual recognition, family tensions concerned with keeping the notion of being trans* a secret and supports by family and wider social networks. Acceptance and support were sometimes associated with loss and grief in the post-surgical phase. For some, traditional family values were threatened and a lack of knowledge of trans* issues in those networks exposed the problematic notions of keeping secrets and symbolic religious rituals. Family support varied among the participants along the acceptance/non-acceptance continuum and SRS was a source of grief to some family members where some participants felt socially excluded from those networks. Additionally, the ways in which transition is socially constructed in institutions such as the family sometimes echoes the mainstream views of society where being trans* is reduced to a source of stigma and discrimination.

In the following chapter, I turn the discussion to perceptions of the medical and legal selves. The medical self is bound in the participants' interactions with the healthcare system, and in particular the surgical process. However, the findings of this study suggest inconsistencies in medical processes. These findings directly relate to one of the aims of this study – the participants' perceptions of whether or not their needs were met in the SRS process. The legal self explores the relationship between the participants and the Commonwealth, State and Territory legislatures. The analysis highlights the complexities of the current systems of governance

which impede a fluid transition for participants and place unnecessary barriers to identity development.

Chapter 6: Ways of interpreting: medical and legal selves

> *It would be nice if the systems in different states (Victoria and South Australia) in Australia talked to each other. Having moved 3 times during my transition was quite strange having to start at the beginning again as far as the system was concerned every time I moved. I kind of felt like I had an awful lot of money spent on psychiatry that I really didn't need. I understand why they want to make sure that people are making the right decision and they are doing something with eyes open but I really didn't need 4 years of monthly psychiatry. (Jim, male, age 32)*

6.1 THE REGULATION OF BODIES

The quote from Jim above is indicative of the problematic realities that some trans* people encounter when personal pursuits collide with medical systems and legislative requirements. The requirement to repeat previous treatments are created by the variation in State and Territory laws, and the needs of the biomedical models of health in those jurisdictions; a situation that Jim found costly, time consuming and medically unnecessary. It also highlights the significant impact that western models of health are bound in the governance of individuals. A significant focus of this study was to explore needs of the participants in relation to their surgical transition, and to consider whether or not those needs were perceived to have been met. In doing so, it makes a significant contribution to the existing body of knowledge by exploring the psychosocial experiences of the participants pursuing SRS in relation to medical and legal frameworks and assesses if the needs of the participants are being met.

The surgical process from a medical perspective begins with a psychiatric, medical and an endocrinological assessment of the trans* person for surgical suitability. At this significant moment, trans* people finally make the decision to take control and ownership of their embodiment by making the necessary modifications, as argued by Featherstone (1999). That decision ignites the need to succumb control to the system. After all, without the system, the trans* person pursuing SRS cannot claim what they perceive is their innate gender. In order to reclaim their gender, trans* people, similarly to all other patients, form a contractual exchange with the medical profession (Bending, 2015).

Medicine in the postmodern world is driven more by the health needs of the consumer (Bending, 2015), and since the 1970s, the empowered health consumer has often challenged biomedical dominance (Lupton, 2012). For example, patients can change doctors and access information on the internet (Dewey, 2008). This situation can be evidenced by the increase of consumer driven, health related activities associated with medical tourism (Stolley & Watson, 2012). There is one distinct difference for trans* people; a diagnosis of gender dysphoria is a requirement to enter the sanctuary defined as the surgical theatre, and the number of health practitioners in Australia with the appropriate knowledge of trans* issues is limited. This requirement ensures that trans* people need these medical professionals to open the gate (Damodaran & Kennedy, 2000; Meese, 1997), where psychiatrists “exert medical control over ‘gender mobility’ ” (Hirschauer, 1992, p. 130).

According to Bockting (2008), the gatekeeping role is a cleverly managed performance based on privilege when a trans* person is coerced to

convince “medical professionals that one is ‘real’ ” (Dewey, 2008, p. 1). Drawing on Husakouskaya (2013, p. 17), the decision to treat rests solely with the psychologist or psychiatrist. In that process, trans* people play their performance in the role by scripting (Denny, 2004) their own ‘gender mobility.’ As a consequence of this tightly scripted tête-à-tête, there exists a shift in social control; what Foucault (1998, p. 101) terms “a ‘reverse’ discourse.” Additionally, the surgeon plays their role in this performance as the technical modifier (Zola, 1972) of those ambiguous primary and secondary sexual organs. However, drawing upon WPATH (2011a), the surgeon, if feasible, should perform a more nuanced role in the process through forming relationships with mental health professionals, physicians and the client. For Lupton (2003), the pathology of the patient makes the patient visible and open for medical judgement so that diagnosis and treatment can be performed; what Foucault (1975, p. 165) terms the medical gaze:

> Thus, from the discovery of pathological anatomy, the medical gaze is duplicated: there is a local, circumscribed gaze, the borderline gaze of touch and hearing, which covers only one of the sensorial fields, and which operates on little more than the visible surfaces. But there is also an absolute, absolutely integrating gaze that dominates and founds all perceptual experiences.

To pass through the gate, trans* people need to ‘bare all,’ emotionally and corporeally (Irwin, 2002). Speaking on the premise of legal recognition, Bird (2002, p. 366) notes that “a transgender [person] must have his/her genitalia/ body/ psychology put on show before a judge, and often ridiculed by that judge…” Likewise, the analogy remains a reality from a medical perspective, where clinicians scrutinise behaviours and make judgements on

the perceived veracity of the claims made by the transitioning individual (Irwin, 2002). In an autoethnographic account by Dziengel (2014), the author, who identifies as bigendered, described the need to prove his/her need for a double mastectomy, and to present himself/herself as male, effectively losing self-determination. This notion implies that the onus of truth is on the transitioning individual. As Billings and Urban (1982, p. 266) suggest, "after conducting a surgical rite of passage, physicians are accorded moral authority to sponsor passage from one sexual status to another." For this reason, it is evident that the practice of medicine helps shape the everyday lived experiences of trans* people and how meaning is created through those experiences (N. Rose, 2007), as the participants' accounts of their experiences with the health care system demonstrate.

6.2 NAVIGATING THE MEDICAL SELF

6.2.1 Negotiating the system: institutional power

Although clinics and hospitals in Western medicine are necessary institutions for the maintenance of patient safety with their aseptic techniques, modern medical and surgical equipment and sanitary conditions, they are the symbols of social power of the health care system (B. Turner, 1995). They are places of sanctity for the medical bureaucracy to uphold their ultimate importance; "medical dominance and professional power" (B. Turner, 1995, p. 166). According to Allsop (2006, p. 445), "doctors have a privileged social status as they mediate between the world of science…and private experience." The following statement about being a patient in

hospital is from one trans* woman participant with longstanding, previous experiences with the system from both a personal and familial perspective:

> *You can't fight against it [the system]. I think I found that too with the hospital routine of being woken up at 5 o'clock to have obs[ervations] done and things like that. If you complain about that or if you put energy into opposing that it just makes it harder. If you fight against the system, you're only going to lose. (Buffy Dunlop, female, age 44)*

Although there may be a personal choice to cooperate with such bureaucracies, there comes with that, a loss of social control to the system and dependence on the system (Parsons, 1951; Toombs, 1987). With disruption to everyday life, there also exists a loss of self-identity (Toombs, 1987) and a sense of social disconnectedness (Kelly, 1985). As Nordgren and Fridlund (2001, p. 122) state, there is a powerlessness based upon "struggling from a disadvantageous position." That is to say, the surgical patient is reliant upon the knowledge and expertise of the surgeon to perform the surgery with no personal input. These aspects are suggested in the following participant's account:

> *That's an issue with the body that you don't like; no other way to do it I know while they draw Texta on you while you're awake. I suppose you can't be asleep for this but you know. Oh well, shit, I'll just have to stand here then. Psychologically at that moment while you're standing there awake while they're drawing on you where they're going to cut. Yeah…vulnerability…you are so vulnerable. You are giving yourself over to this person. They have your life in their hands, and yeah the finality that this is actually going to happen. (Andrew E, male, age 48)*

For Andrew E, there exists a vulnerability by standing naked as a trans* man with large bosoms and a vagina, while a surgeon objectively draws the incision points on those bosoms for a double mastectomy and the creation of a male chest. Although medically necessary, this part of the surgical

performance reiterates the notion of biomedical dominance through reductionist philosophies (Willis & Elmer, 2011)and the replacement of faulty parts (Sargeant, 2005), while defining the sexual body as a commodity to be maintained (Lupton, 2012). Temporally, this performance suggests that the psychosocial support needed at that moment of time; moments before being anaesthetised; the moment when the finality of the surgeon's knife reframes that ambiguous body does not exist. Vulnerability is further explored in another account below.

> *He (doctor) was describing a surgery that's not indicated and does not work. "You're demonstrating extreme ignorance about this" and again there was that power dynamic. I just needed the script so I reserved responding and challenging him in any way, I just sort of nodded and smiled and pretended I really appreciated him giving me the advice, and left and felt for a moment just quite upset by it. (Jeremy, trans* male, age 29)*

This brand of dehumanisation in the clinical arena can place some trans* people such as Jeremy in vulnerable situations (Levitt & Ippolito, 2014). This vulnerability is supported by the previous discussion concerned with the regulation of trans* bodies, where it becomes almost mandatory to accede to the power of the medical profession in order to obtain access to health care services. This finding is supported E. Smith et al. (2014, p. 74) in their study on young people where 11% of the 189 participants chose silence over complaint in order to ensure receiving treatment. This power is an unearned, taken-for-granted cisgender privilege based upon a superior attitude and a lack of knowledge which, according to Ansara and Hegarty (2013, p. 162), "delegitimises people's own designations of their genders and bodies." Another participant felt exposed and vulnerable as she was assessed for surgery:

> *He [doctor] physically examined me and I think that like freaks me out because I was young. I was in a room with a doctor that I didn't really know and you know like he examined my genitalia to assess me for surgery. Looking back I know now and I freaked out and my father can remember that day as well and he said you came out of that room and you were just like really, really freaked out. (Phoenix, female, age 42)*

Similarly to Andrew E, Phoenix was placed in a vulnerable situation having to expose her genitalia as a naïve and intimidated teenager. Further exploring that viewpoint, in the assessment process for surgical approval, one participant perceived that the treatment he received from his psychiatrist was inappropriate to the point of being intrusive and neglectful:

> *They didn't really have any guidance. The psychiatrist was useless. I saw him twice for all of an hour or half an hour and so he didn't know me from anyone. He just grilled me and asked me about my sex life and very inappropriate questions to ask someone who couldn't even say the word sex at that time or name my body parts. (John, male, age 34)*

This approach to evaluating trans* suitability for surgery is embedded in the Freudian psychosexual stages of development (Nizette, 2007), and becomes an abuse of power in the doctor-patient relationship. This abuse of power supports the findings of Husakouskaya (2013, p. 18), who found that a trans* man participant experienced sexual and corporeal humiliation and degradation at the whim of the attending psychiatrist during the treatment and diagnosis process. This finding is supported by T. Jones et al. (2015), where one participant suspected he was treated as a curiosity so that the health professional could view his genitalia. In contrast, an English study (Speer & McPhillips, 2013, p. 388) on transsexual patients' experiences with psychiatrists found that the participants perceived "difficult/challenging

interactions an opportunity to question self and reflect on life-changing decisions." These findings diverge from the current study. According to Dewey (2008), some trans* people, through their interactions with medical professionals who may have little knowledge of trans* issues, face medical stigma through that power dynamic.

From Parker's (2012, p. 166) viewpoint, stigma is a social practice that is explicitly associated with domination. For Berger and Luckmann (1966, p. 88), based on social and historical circumstances, the medical profession parades this societally perceived "right and beneficial" power complete with "outlandish costume to incomprehensible language." How trans* people are treated by some in the medical profession in this one-sided power dynamic suggests a process of what Weiss, Ramakrishna, and Somma (2006) argue is social disqualification based upon the notion of a particular health condition (such as GD) and the characteristics of a person's identity (such as a trans* person). Finally, in the words of C. S. Lewis (1946, p. 40), "…what we call Man's power over Nature turns out to be a power exercised by some men over other men with Nature as its instrument." The end result is another example of social oppression and systemic discrimination.

6.2.2 Surgical readiness: an (un)informed approach

In an ideal world, the readiness for surgery should be a collaborative, multidisciplinary effort between the client and the medical/surgical team based upon the notion of informed consent (Wylie et al., 2014). All the participants, from their personal perspectives, perceived their corporeal readiness for surgery. It is manifestly apparent throughout this discussion

that change was a process needing to occur, and the following accounts demonstrate that need:

> *[I was] 150% [ready]! As I'd said I'd done my research and I'd asked questions of the surgeon. Umm…I don't think there was anything else that I could do to even prepare myself more. (Irish, female, age 78)*

> *I was totally ready for the surgery. I'd been ready for the surgery for 20 years. But I think it's really important for surgeons to make sure that their patient is ready. (Robert, male, age 31)*

These accounts also suggest that readiness is grounded in the knowledge and support of, and effective communication with the surgeon. These perceptions suggest a reframing of the doctor-patient relationship through mutual understanding, and the recognition that a collaborative model of treatment based on trust (Dewey, 2013) is a recipe for success. This relationship suggests a negotiation in the power dynamic, and one in which the patient is spatially and temporally situated as an "agent of change" (Metzl & Herzig, 2007). However, lack of knowledge and information about the surgical process can lead to uncertainty and the possible psychosocial consequences of a lack of knowledge, as related in the following participant's account:

> *I probably didn't have enough information to really make informed decisions about the surgery. I probably didn't have enough information to make informed decisions about whether or not I'd see a counsellor or what I'd see a counsellor about but I was ready. (John, male, age 34)*

The decision to proceed to the 'final cut' is bound up with confusion about the decision making process and the need for further counselling.

There is a need to be fully informed about the surgical process, however, the reality of facing the 'final cut' after the prolonged performance of waiting in the wings takes precedence. As Vitale (2010, p. 107) states, the final cut is "a true turning point." Despite his personal readiness, John's experience suggests that he wasn't provided with the tools to be psychologically or practically prepared in order to make an informed decision as suggested by Coleman et al. (2012). On the other hand, one trans* woman participant had her psychosocial needs met in the lead up to the surgery, as the following account relates:

> *It was so simple and definitely it was because of the help that this counsellor had given me in terms of getting myself ready for it [transition] and that same help with leading into the surgery and things and so I would see her completely independently of seeing [name of psychiatrist] at the [name of clinic]. (Buffy Dunlop, female, age 44)*

Given the serious nature of the irreversible intervention known as SRS, it is reasonable to conclude that readiness is a key issue and that surgeries should not be considered until a complete mental health assessment has been conducted, appropriately documented, and clients have met the suitability criteria (See Footnote 57). The collaborative nature of this work is reinforced by WPATH (2011a, p. 55) when they state "by following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body." From an ethical perspective, informed decision making comes down to effective communication between the surgeon and the client, as procedures associated with SRS are a "private mutually consenting contract between a patient and a surgeon" (WPATH, 2011a, p. 55). It is the client's

responsibility to draw their own conclusions on the 'final cut' based upon the information and support they receive, as suggested in the following account:

> *Oh yeah I would have been happy to have it done earlier if I could have it done earlier. My only areas of apprehension were how exactly it was going to look afterwards. You never really know what the scars are going to be like and whether or not I'd get nipple sensation back because I wanted it but I knew it wasn't a guarantee. (Jim, male, age 32)*

This perception reiterates the personal aspects of SRS, the necessity of surgery and the feeling of comfort of their embodiment that trans* men find more importance in than the perfection of the final result (Dozier, 2005). It also suggests that Jim had a "realistic expectation of outcomes" (WPATH, 2011a, p. 57). From another participant's perspective, knowledge of processes was not important. The following account suggests a collaborative arrangement existed; there was trust in the system and the expertise of the surgeon.

> *I remember getting the letter. I knew and it was something that I'd worked two years towards so I knew it was a big moment, but I didn't have a lot of information and that's solely because I never sought it. I think if I'd asked the doctors involved and [doctor's name], if I had asked him specific questions, they would have been answered, but I didn't care to know. It wasn't until much, much, much, much later – like you know recently, that I even knew what was done to me. I didn't – I didn't care. (Phoenix, female, age 42)*

Similarly, another trans* woman developed a collaborative therapeutic relationship with her surgeon:

> *He [surgeon] was happy to tell me. If I wanted to I could go back now and ask him what was going on but it wasn't something that I needed to know and he really respected those boundaries. But at the same time I knew everything that I was up for heading into the surgery. I made a deal with him that you know there's stuff…obviously there's stuff I need to know so I can give informed consent. There's stuff I*

> *want to know because I'm curious and there's a whole lot of stuff I just don't want to know. (Buffy Dunlop, female, age 44)*

Buffy developed a trusting relationship with her surgeon by noting the limitations imposed on the level and types of information that was required to make an informed decision. Equally important, the level of support provided suggests familiarity and prior knowledge of treating trans* people by the surgeon. It is well documented (Dewey, 2013) that some health professionals will either refuse treatment or withhold treatment based upon a lack of formal knowledge or training about issues relating to trans* people. One participant in T. Jones et al. (2015) study described being refused treatment for the reason that the health professional had no knowledge of trans* people. There are also ethical concerns by some surgeons of mutilating functioning body parts (WPATH, 2011a). The mutilation of body parts can also present its own dilemmas for clients from a psychosocial perspective:

> *My psychiatrist (name of doctor) did talk for a bit about how you need to be very prepared; like if you have any attachment to your female body parts, you need to be prepared to mourn them because some people even if they are FTM, they still mourn the loss of their femaleness. (Robert, male, age 31)*

Although mourning is a normal reaction to a personal loss, it is experienced in a social context (Rosenblatt, 1988). Anticipating the loss of functioning yet unwanted organs is embedded in the knowledge that recognises the possibility of grief and being prepared to face the loss. By providing such information prior to surgery, the attending psychiatrist has engaged in a social process with the client to find "purpose and meaning in

their lives" (Fulton et al., 1996). In the context of experiencing life as a trans* man (or woman for that matter), it could be argued that a significant attribute of a person (femaleness) is lost and been reconstituted in the surgical process (as maleness). As Rosenblatt (1988, p. 68) argues, "even for losses that are desired…the loss of social context may produce grief." Furthermore, Wylie et al. (2014) argued that following surgery, issues such as depression and other mental health concerns may need addressing. As confirmed by another participant, there were several areas of concern where there was no guidance or preparation on possible side effects and adverse outcomes:

> *There were a lot of things that weren't talked about. Yes…umm…sort of the side effects of not just dilation, but drugs and so on and so forth; how it would sort of impact on your life in many respects. The other thing of course was that I had been talking to my daughters and lady friends about feminine hygiene which was never broached and this is a very serious area of concern for the simple reason that there can be a lot of infections caused as I was to find out with granulation. But this happened before Xmas and by Xmas I was feeling a bit low and then after Xmas I went into this 'post-op blues' situation where I quite honestly I could have jumped off the bridge. (Irish, female, age 78)*

This perception by Irish suggests that the expected positive outcomes of surgery were replaced with a negativity based upon a lack of medical guidance and information; effectively removing meaning from the surgical experience. The surgery, although psychologically and corporeally necessary, was consumed by a state of dismay related to unknown outcomes. The physical and emotional reactions to these specific events disallowed a seamless transition. Interestingly, this account also suggests being informed is the client's responsibility, not their right. As Wylie et al. (2014, p. 19) suggested, successful outcomes are reliant upon "adequate psychological preparation…including properly informed consent about

benefits, risks and outcomes." Similarly, another participant felt unsupported by the medical profession prior to surgery, despite asking for assistance:

> *I didn't really have any support. I did mention it to the doctors and they didn't seem to have a solution to send you anywhere or do anything. In fact the psych[iatrist]s didn't even send me to a counsellor or did not suggest working in tandem with psychologists, and I asked them for it, and they said…the response I got from the [name of clinic] was "Well we've got that for family members, not for you." (Andrew E, male, age 48)*

In their *"Good practice guidelines for the assessment and treatment of adults with gender dysphoria,"* Wylie et al. (2014) concern themselves with a therapeutic approach to support the transitioning individual prior to surgical treatment, as some individuals need to explore psychosocial issues not necessarily associated with their gender identity. Similarly, WPATH (2011a, p. 27) note that mental health professionals need to ensure clients are "adequately prepared…to have functioning working relationships with their clients…and providing them with appropriate medical services." This account suggests that the level of instrumental support offered failed to meet those expectations, resulting in a possible loss of trust. According to Semmer et al. (2008, p. 246), clients expect this instrumental support from medical professionals as they "focus on the problem." The following account suggests side-stepping the problem.

> *I had heard of some regretting the procedure. What if I would be one of those? What would happen to me then? All these things played on my mind. I remember the surgeon saying to me "Well you wouldn't be seeing me here and now if you weren't suitable." But I've done some reading as well about some people saying they were misdiagnosed and shouldn't have had the operation. These were some of the things going through my head. (Dee Dee, trans* woman, age 49)*

According to Dewey (2013), the therapeutic relationship between health professionals and trans* people is challenging and building trust is difficult due to the power invested in the medical profession (the gatekeeping role) and the interplay between the SOC [Version 7] (WPATH, 2011a) and the DSM-5 (American Psychiatric Association, 2013). The participants in this study have made it through the gate. Thus far, the research suggests an inconsistency in the approaches and attitudes of health professionals. Equally, it also suggests variations in the acquisition of knowledge by the participants in this study to inform their decisions to undertake such radical surgery. However, there are tensions between the biomedical model and its reductionist philosophies laden with medical power and doctor-client relationships based upon mutual understandings and respect for expertise. Participants' experiences suggest the language used in healthcare encounters is an important issue.

6.2.3 Professional and gendered language: (dys)respectful communication

An important component of any supportive therapeutic relationship between health professionals and their clients is communication and the language used (Fong Ha & Longnecker, 2010). Ideally, a therapeutic relationship is formed as a collaborative partnership in communication practices (Speer & McPhillips, 2013). According to Fong Ha and Longnecker (2010), it is often the 'bed-side manner' of health care providers that determines the effectiveness of communication. Some participants felt affirmed and comfortable with the gendered language and approaches of health professionals. On the other hand, some participants felt emotionally

upset by misgendering and unsupportive language in their healthcare encounters during the surgical process and beyond.

The participants in this study identified almost exclusively as male or female. This normative construction of identity resides in the notion of the binary nature of gender where the use of pronouns such as 'he', 'him', 'she', and 'her' would normally be acceptable. The two participants who departed from this normative construction identified themselves as trans* male and trans* woman; effectively "articulating their transgender subjectivities" (Hines, 2007, p. 78). 'He,' 'him,' 'she,' and 'her' may still be acceptable, however, gender-neutral pronouns such as 'they', 'zhe', 'ze' and 'hir'[81] may be more acceptable. The point is that the use of personal pronouns is a personal choice and becomes a marker of a person's identity. The following accounts relate the participants' positive experiences in relation to the language encountered in the medical arena:

> *I think it was a blur for me until they were literally wheeling me out of the room. The [hospital] staff were really good because when I look back, I'm surprised people did like use the right pronouns because I look back at photos of me at that point, I now feel that I looked quite female. (Leroy, male, age 31)*

> *You only encountered the nurses and the surgeon only popped his head around you know. Yeah but there was nothing…everyone referred to me by male pronouns and it was all very respectful. It was good. (LM, male, age 27)*

Leroy and LM felt supported and affirmed by the use of the correct pronouns associated with their preferred gender. In an American study

[81] 'Zhe', 'ze' and 'hir' are recent additions to the English language to denote the non-binary nature of gender.

(Hagen & Galupo, 2014) on the experiences of trans* people dealing with healthcare providers, the authors argue that those individuals who undergo surgery are generally affirmed in the binary notion of gender. Additionally, Hagen and Galupo (2014) argue that improvement to the healthcare needs of trans* people can be maintained when positive and affirming experiences are delivered by health professionals. The above accounts align with that assertion through the use of language referring to 'male' and 'female'. In opposition to this notion, the use of inappropriate language by health professionals was of concern to one participant while recovering from surgery:

> *I had chest surgery and that was the most defining moment of my transition I think because I think for a man to have boobs it doesn't feel great. So yeah that was a really good feeling. So after that surgery, I think the physical pain, it wasn't so much as the second surgery. So the second surgery really weakened me and the hospital experience wasn't that great and the nurses confused the pronouns and that was just bad. (Daniel, male, age 25)*

Being in a debilitated physical state following radical surgery left Daniel feeling unacknowledged and nullified as the person he is at a time when thoughts of the euphoria of previous surgeries were on his mind. Similarly, another participant had negative experiences following surgery in written communication with the anaesthetist:

> *The only thing that pissed me off with the whole surgical process is when the anaesthetist sent me the bill afterwards. It was addressed to Ms, and I was like…that really pissed me off. You've just performed a gender reassignment surgery on me and you're sending a letter to Ms. (LM, male, age 27)*

The study reinforces a UK study concerned with mental health and emotional wellbeing, where McNeil et al. (2012) found that language was

hurtful in relation to pronouns and body parts. Of 558 trans* participants in a general healthcare setting, 452/558 (81%) experienced the use of incorrect pronouns, both on purpose (26%) and by mistake (55%). Additionally, according to McNeil et al. (2012) the use of incorrect pronouns was experienced in Gender Identity Clinics. Of the 382 trans* participants who attended those clinics, 69/382 (18%) experienced the use of incorrect use of pronouns. McNeil et al. (2012), rightly note the problematic use of language in settings supposedly designed to care for trans* patients. This finding is further supported by the findings of E. Smith et al. (2014, p. 74) where participants avoided interactions with healthcare providers due to "deliberately and consistently being misgendered" and feeling invalidated.

Participants in Hagen and Galupo's (2014) study voiced the importance of being recognised as themselves by medical providers. These accounts by Daniel and LM highlight the disruptive nature of misgendering (McLemore, 2015) and the deligitimisation of identity (Ansara & Hegarty, 2013) and are in keeping the findings of Hagen and Galupo (2014). In Riggs and Due's (2013) study previously described, interactions with staff were reported as being negative with physical health professionals, while with mental health professionals, there were reports of misgendering language. The findings in this study both support and refute those findings.

Besides the misgendering and the deligitimisation of personal identity, I can conclude that such disrespectful communication reinforces the notion of medical pathologisation by some health professionals in dealing with trans* identities and implies the notion of institutional erasure. As Namaste (2000, pp. 4-5) states, "erasure is a defining condition of how transsexuality is

managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible." Additionally, the principles of a collaborative partnership are not practised (Speer & McPhillips, 2013). Misgendering and mispronouning, while being disruptive and demeaning, are, from a social constructionist perspective, symbolically utilised in social interactions to denote a ranking system, where one class of human is ranked above other classes of humans, and sanctioned by society as legitimate (Berger & Luckmann, 1966).

The stigma and discrimination of misgendering and mispronouning or not is a site of disruption at a personal level, and the language imposed upon some SRS recipients from a biomedical perspective does little to improve the healthcare they receive or meet their psychosocial needs. Just as there needs to be an informed approach leading up to the surgery, medical support during and following surgical transition are just as important for psychosocial wellbeing.

6.2.4 Post-surgical medical support and follow-up

Psychosocial processes exist in tandem with the physical transformation through the recovery period. The perioperative period is the time when a paradigm shift from natal to preferred gender occurs. It is a time of great physical and psychosocial adjustment and therefore it is important that healthcare professionals provide a supportive role to ensure a fluid transition. The participants in this study often reflected on their recovery period and the treatment they received, showing conflicting perceptions of the support from healthcare professionals, both while in hospital and

following discharge. One participant felt both confused, upset, confronted and resigned to the process in hospital, as the following account relates:

> *I remember crying a lot – I don't know why I was crying – I thought it was just the pain. The surgeon came in on the second day to check on me. I was crying when he came in. He said "Why are you crying? You got what you wanted." I was in such a state. I just said "I don't know." I wasn't used to being the new me then. But when I thought about it later, I thought I wasn't happy with it and it made me a bit angry, but what can you do? He was right. I got what I wanted, so why should I be crying? (Dee Dee, trans* woman, age 49)*

This disregard of Dee Dee's psychosocial needs in the guise of scientific neutrality and professional authority further objectifies the trans* body as a site of disruption and resulted in a nullification of her emotions. Additionally, at this time of physical and emotional upheaval, the fluidity of the transition was disrupted. Conversely, another participant felt supported by the medical team, as illustrated below:

> *And then the nurse in Intensive Care was really, really nice. She was very gentle and very caring. I remember becoming conscious and she was just like really gentle and very attentive to my needs and then knocked me out again and then 24 hours later I was taken back to the ward. What I noticed during that time in hospital his [surgeon] treatment of the people were very individual and very unique and I found him to very sympathetic, very understanding, very gentle and it's the same with [the psychiatrist]. I've heard from people that it was a nightmare experience with her. With me, she was amazing. (Phoenix, female, age 42)*

The perceived support received in Phoenix's experiences in the ICU exemplifies the supports needed at this time. Phoenix felt comfortable with the medical professionals and trusting relationships were formed which created a meaningful reality. The treatment received conforms to the 'medical gaze's' acceptability of this participant's personal and social self. As Dewey (2008, p. 4) suggests, trans* people read the medical messages they

receive based upon their treatment. However, the treatment could be interpreted in terms of Denny's (2004, p. 29) "transsexual model," with its 20th century notions of passing, youth and sex appeal, where "the clinics attempted to turn out well-adjusted graduates."

Just as there were supportive instances of care, the same participant perceived support was lacking and dismissive at ward level in the hospital, as related below:

> *And then there was another nurse who was like…she was just like dragging her feet and all of this like she had a really bad attitude. I don't know whether she was having a bad day or that's just who she was or whether she didn't understand trans* people. And yeah and I was in pain. I was in a lot of pain through this process. For me it was particularly painful. I was prescribed pain medication, and I said to her "can I have my pain medication?" And she's like "you've already had it" and I said "I don't need that fucking attitude – you know I haven't", and I had her thrown off my room. (Phoenix, female, age 42)*

For Phoenix, there was not only a lack of physical care in respect to her pain medication, the care she received disregarded her psychosocial needs as a trans* person undergoing SRS. An assumption was made about care required resulting in a lack of communication and the sense of not being believed. This disbelief affected the therapeutic relationship based on mistrust. Similarly to the medical profession, the culture of nursing is power laden (Nordgren & Fridlund, 2001) and effective interpersonal, patient-centred communication builds trusting relationships and improves the quality of care (C. McCabe, 2004). This experience aligns with a finding in a qualitative study by Nordgren and Fridlund (2001) on patient perceptions of self-determination. In that study (Nordgren & Fridlund, 2001), cisgender participants described being questioned and not being trusted by nursing

staff. According to Wylie et al. (2014), nurses play a pivotal role in the support needs of trans* people following surgery firstly from a physiological perspective, but just as importantly, from a mental health perspective. The authors (Wylie et al., 2014) expand upon this by stating that nurses need knowledge of issues of concern to trans* people. These sentiments are reiterated by Merryfeather and Bruce (2014). Furthermore, on the concept of trans* understandings, Merryfeather and Bruce (2014) argue that nursing education needs to include the trans* experience through curriculum development and research. From another participant, support following surgery was dependent upon the profession, as related below:

> *There was plenty of support from my surgeon. I could just ring up and say I had a problem and he would say "can you get your bum down here on such and such" and that was it. From a psychiatric point of view, once you got your letter of acceptance that was it. And the same from the endocrinologist other than "let's say every three months for the first bit, and every six months and then a year after that." And now of course I'm at the stage where he simply says "there's no point in seeing you." To my knowledge there is no [psychological] follow-up and this is a big problem and nowhere you can go. So no, there is no support. This is not like the American system where there are follow ups directly after and continuous for a while, so we go through and we are virtually left on our own. (Irish, female, age 78)*

While there was surgical and endocrinological support for the physical aspects of the transition, psychosocial support was perceived to be lacking. This lack of support left Irish feeling isolated and alienated at a time of great psychological adjustment to a different physicality, with nowhere to turn. This perception is supported by another participant, as noted in the following excerpt:

> *…what we have to go through to rebuild lives after surgery is no mean feat and it's quite public and vulnerable and right out there and most people wouldn't deal with it well let alone us; semi damaged*

> *goods if you like. You have to deal with it and you kind of get asked to do it on your own. I was sort of staggered in a way that post-surgery there wasn't a nice list of who you could go to if you wanted to. (Andrew E, male, age 48)*

Similarly to Irish, Andrew E felt isolated and vulnerable about his new corporeal embodiment and felt the need for further guidance through the postoperative phase of treatment to aid his wellbeing. This finding is in keeping with the findings of Husakouskaya (2013, p. 20) in a South African study where "it [psychological assessment] is marked by a lack of proper attention to their psychological well-being during and after medical interventions (for example, surgeries)." Furthermore, McNeil et al. (2012) and McNeil, Bailey, Ellis, and Regan (2013), reported the participants' needs for ongoing support and care postoperatively and that the lack of support affected wellbeing. In contrast to the above accounts, one participant found the level of psychological support after discharge was appropriate and welcomed, as indicated below.

> *I had a follow-up appointment [with the psychiatrist] a couple of months later and he wants to see me again in February which will roughly be a year after. I don't know that there's much that I'll particularly get out of that but if there's follow up work that they'd like to do at the clinic to make sure everything's on track and that perhaps improve their services or something, then I'm more than happy to go along and do that. (Buffy Dunlop, female, age 44)*

Although it is unclear whether Buffy felt the need to pursue follow-up appointments with the psychiatrist, she was willing to pursue that course of action at the request of the gender clinic in the interests of providing trans* people a better service at the clinic. Nonetheless, Buffy's actions are in contradiction to what normally happens postoperatively. According to

Damodaran and Kennedy (2000), SRS recipients are advised to seek follow-up support through the gender clinic, but very few do based upon a reluctance to review their past. In effect, this reluctance suggests reclamation of self-determination by closing the gate. It equally suggests a process of personal erasure. As previously noted, some trans* people following SRS undergo a process of personal erasure defined as stealth. This personal erasure can inhibit receiving appropriate health care by withholding such information from healthcare providers. In simple terms, a man with a uterus and a woman with a prostate go against the physiological norms of sex and gender.

There are tensions between the accounts of the participants on the provision of support and follow-up advice from the various medical professions. Therefore, I can conclude that the perceived levels of support throughout the surgical transition were inconsistent. This conclusion is supported by the findings of Couch et al. (2007), where support by healthcare providers ranged from acceptance and feeling supported to being treated with hostility and disrespect. The findings also converge with those of Riggs and Due (2013) who found in their study concerned with the health experiences of trans* and gender diverse people that care ranged from caring, knowledgeable and responsive to pathologising and inappropriate. In the current study, physical support provided postoperatively, the core business of surgery was generally perceived as positive. This finding supports the findings of Jokić-Begić et al. (2014) in a Croatian study, the participants felt psychologically supported by the surgeon's expertise and acceptance. However, the levels of psychosocial support was inconsistently

applied at the individual health professional's level, suggesting support was based upon the knowledge of trans* issues and the acceptance of trans* people by healthcare providers. Furthermore, this conclusion contributes to the perception of the participants' needs not being met.

6.2.5 (Un)met needs

All the participants in this study indicated their personal satisfaction in transcending their physicality (being regardful of some works in progress). Undergoing SRS met their physical needs, concurring with the findings of Jokić-Begić et al. (2014). However, meeting the needs of trans* people pursuing SRS goes beyond the physical; needs are dependent upon the knowledge of wider social networks, including the healthcare network. A common thread supported by participant accounts is concerned with my original premise that once approval for surgery is received, little support exists (See Section1.4.2). This assertion is further supported by the following participant's account:

> *I got most of the information about being transsexual on the internet, although I'm not sure that a lot the information out there is very accurate…just a lot of blogs that I came across all over the place. I did have good contact with a community group and they were helpful in trying to sort through things with me, but as far as doctors and psychiatrists go, they seem to be interested in getting you to the point of surgery and healing and that's it. Well that was my experience anyway. (Dee Dee, trans* woman, age 49)*

This account suggests that the psychosocial aspects of surgical transition are disregarded by medical professionals. In their guidelines for transgender care, Bockting et al. (2006, p. 38) suggest just that when they state that following writing letters of recommendation for surgery, there should be a "discussion of any further resources sought by client in

continuing process of transition." However, I would argue that this recommendation is inconsistently applied, further supporting the findings of Husakouskaya (2013) that there was a lack of attention when required during and after treatments. Several participants in my study requested such resources, but their voices were not heard. Therefore, for Dee Dee, having access to networks through the internet and community groups was an important part of her journey. Informal gathering of internet information through blogs and community sites about such topics as choice of surgeon, surgical facilities, risks of surgery and the experiences is becoming more popular when other options are not available, which aligns with the findings of Jokić-Begić et al. (2014) in their Croatian study. However, the context of Croatia requires the accessing of information on the internet as hormonal and surgical treatments are not available in that country (Jokić-Begić et al., 2014). Nonetheless, as the following participant account suggests, getting information about transitioning is a difficult process, and leaves some trans* people confused as to their options:

> *The medical profession don't seem to know what we need to know and we don't know what we need to know. The surgery is sort of the least of your worries because you're under and it's their job. That's what they need to know, not what you need to know. (Andrew E, male, age 48)*

The following account reiterates the perception that knowledge of what trans* people need is lacking in the medical community. Equally important, the account suggests that trans* people themselves appear to be part of the problem and need to be part of the solution:

> *There's a lot out there to be done in the medical fraternity to understand our needs and our change but on top of that there is a lot*

*in the trans*community that they have to do to come to terms with this and understand. (Irish, female, age 78)*

Overall, participants perceived that navigating the healthcare system was an intrusive, positive, confusing, supportive, lacking, dismissive but necessary experience to obtain approval and subsequently undergo SRS. Participants'' accounts suggest that some health professionals provided the supports needed to ensure a fluid transition. However, in contrast, other health professionals did not provide best practice for these people, and in some cases, it was a requirement to make it through the 'gate'. This suggests that, for some participants, navigating the system was a challenging process. This interpretation supports the findings of Roller, Sedlak, and Draucker (2015), who found that to obtain care, trans* people did what they had to do in order to navigate relationships with healthcare providers. Therefore, I would suggest that there exists a need for medical professionals and trans* people to be mindful of the complexity of transition. Based upon the participants' experiences, I now explore the findings of the medical self in relation to SOC [Version7] (WPATH, 2011a), which suggests that further refinements to the SOC [Version 7] (WPATH, 2011a) are warranted.

6.2.6 SOC 7: a critical analysis

Previously, the evolution of the SOC [Versions 1-7] (WPATH, 2011a, 2011b) was fully described to contextualise their history (See Section 2.4). The 7th version of the SOC (WPATH, 2011a) began with a process of revision in 2006, whereby members of WPATH were asked to review sections of the SOC [Version 6] (Meyer et al., 2001). Following the peer review process, final drafts were submitted and published. Committees and

subcommittees were formed to debate and fine tune the recommendations for change and a writing group was established. According to WPATH (2011a), changes were based on expert advice, scientific evidence and consensus amongst the consultative groups. The final document was approved by the Board of Directors of WPATH in September 2011. The following sections explore areas of the SOC [Version 7] (WPATH, 2011a) concerned with eligibility and readiness for surgery, psychotherapy and communication. It should be noted that this analysis only applies to the English version of the guidelines for the reason that, as WPATH (2011a, p. 4) state "terminology in English may not easily be translated into other languages."

Exploring eligibility and readiness in the SOC

As the participants accounts show, eligibility and readiness for surgery are important procedural aspects of transition. One of the papers that went through this screening process was related specifically to the eligibility and readiness criteria for SRS. De Cuypere and Vercruysse (2009) reviewed the literature in order to determine the best evidence available and was concerned with the adverse outcomes of SRS such as regret and suicide. The focus was on negative and positive "prognostic criteria in order to evaluate the eligibility and readiness criteria for surgery" (de Cuypere & Vercruysse, 2009, p. 202). A summary of the prognostic criteria is displayed in Table 6.

According to de Cuypere and Vercruysse (2009), regret following SRS manifests itself primarily as a result of an inadequate diagnosis and the existence of major psychiatric comorbidities. Other sources of regret include

dissatisfaction with surgical results, either functionally or aesthetically, and "an absence of or a disappointing real-life experience" (de Cuypere & Vercruysse, 2009, p. 196). For suicide, the authors (de Cuypere & Vercruysse, 2009) concluded that there is little evidence to suggest that SRS is a causative factor from the limited case reports available.

Table 6

Prognostic Criteria of Eligibility and Readiness for SRS

Negative Predictive Factors	• Choice of a heterosexual sex partner before SRS, which results in a homosexual couple after SRS • GID with transvestism or autogynephilic[82] transsexualism • An age over 30 years at first request for SRS • Psychiatric co-morbidity and personal instability • Inadequate social functioning, indicated by periodical or full dependence on social assistance • Poor support from the patient's family • Dissatisfaction with secondary sex characteristics at initial assessment • Unsatisfactory surgical results
Positive Predictive Factors	• Sexual attraction to same-sex partner before SRS, that is, GID with homosexual orientation • Early onset of transsexualism • Age under 30 years at first request for SRS • Absence of coexisting mental illness (psychosis) and emotional stability in life history • Good familial and social support after SRS • Satisfactory surgical results

Note. Adapted from "Eligibility and Readiness Criteria for Sex Reassignment Surgery: Recommendations for Revision of the WPATH Standards of Care," by Griet de Cuypere & Herman Vercruysse Jr (2009, pp. 197-199).

Several studies (Landén et al., 1998; Lawrence, 2003; Olsson & Möller, 2006; Y. Smith et al., 2005; van Kesteren et al., 1996; Weyers et al., 2009) have included regret following SRS in their findings, mostly identifying a multifactorial causation. However, the majority of SRS recipients in the general trans* community experience little or no regret. The negative

[82] "Autogynephilia is defined as a male's propensity to be sexually aroused by the thought of himself as a female" (Lawrence, 2011, para. 1)

predictive factors associated with regret as displayed in Table 6, according to de Cuypere and Vercruysse (2009), should be considered in the diagnostic phase of treatment, if patients present with a combination of those factors. This approach suggests the continued psychopathologisation of trans* identities by clustering negative predictive factors in order to disqualify prospective surgical applicants. On the basis of this clustering, some participants in this study could have been interpreted as predictive of regret and potentially disqualified from surgery. For example, Irish, was 66 years old, lived in a heterosexual relationship for the majority of her life prior to SRS and was possibly dissatisfied with her surgical results due to granulation of vaginal tissue. Similarly, Dee Dee was over 30 when first presenting for assessment, was married prior to surgery and remained married after surgery. These factors reduce the trans* phenomenon to a cluster of symptoms to be recognised and managed.

The eligibility for surgery in relieving gender dysphoria is based upon the already known effective outcomes of the surgery in the areas of quality of life (Kuhn et al., 2009; Lawrence, 2003; Parola et al., 2010) and patient satisfaction with surgical outcomes (de Cuypere et al., 2006; Eldh et al., 1997; Lawrence, 2003) to name but a few studies conducted in this area. The vast majority of retrospective studies indicate the success of SRS as a treatment for the majority of recipients. This analysis suggests that, from a biomedical perspective, the corporeal transformation of 'wrong bodies' remains the most important aspect of surgical transition in relieving dysphoria for those pursuing surgery. However, readiness for surgery is based on subjective decisions by the clinician and the trans* person's adherence to the

criteria (de Cuypere & Vercruysse, 2009), which indicates a sanctioned return to the notion of gatekeeping.

According to the guidelines (WPATH, 2011a), one role of mental health professionals is to prepare clients psychologically and practically for surgery if that is the client's goal. To illustrate these important aspects, the guidelines state the:

> ...client has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate...has made an informed choice about a surgeon to perform the procedure; has arranged aftercare. (WPATH, 2011a, p. 25)

In this study, some participants perceived physical readiness for the surgery, but indicated the need for further psychological interventions in the lead up to and beyond surgery in order to navigate the surgical process, as the following participant account relates:

> *I don't recall seeing anybody besides the surgeon and I often thought that was a bit odd. I was extremely nervous and anxious about having the surgery and I told the surgeon and my GP doctor this but no one referred me to see anyone. It was good my wife was there. She has always been my tower of strength. But I think it would be good to have seen some type of professional person to help me through it [surgery]. (Dee Dee, trans* woman, age 49)*

Other experiences of readiness were expressed by other participants. For example, John expressed his concern about not having enough information about undergoing the surgery. Andrew E perceived there was no support, asked to be referred to a counsellor but was denied this service as counsellors were only available for family members. I understand that clinical guidelines are flexible instruments. However, one finding of this study

suggests that the guidelines may be too flexible. The vague approach in the WPATH (2011a) quote above in reference to the trans* person's needs does little to enable the transitioning individual to make that transition fluidly, and in that respect the SOC [Version 7] (WPATH, 2011a) falls short of meeting the needs of some individuals. According to WPATH (2011a), treatment options may vary and the guidelines may be modified in individual circumstances based upon a client's anatomic, social and psychological rationale, and, local cultural and legal issues, for example. Nonetheless, as A. Johnson (2015) argues, health practitioners can choose to ignore the guidelines because of their flexibility.

Exploring psychotherapy in the SOC

As previously indicated, several treatment options exist. For the individual whose ultimate goal is SRS, one such treatment option is psychotherapy. However, psychotherapy is not a mandatory requirement for surgical or hormonal therapy (WPATH, 2011a, p. 28). Nonetheless, de Cuypere and Vercruysse (2009) consider that psychotherapy is an appropriate tool to detect psychiatric comorbidities in trans* people not necessarily associated with their gender dysphoria. As a result of the review, de Cuypere and Vercruysse (2009) recommended those patients presenting with an Axis 1 diagnosis[83] undergo pharmacotherapy and/or psychotherapy prior to surgery. For those with an Axis 2 diagnosis, de Cuypere and Vercruysse (2009) recommended psychotherapy as an absolute requirement for surgery. In the approved version of the SOC [Version 7] (WPATH, 2011a,

[83] According to Widiger and Shea (1991, p. 399), Axis 2 disorders include personality disorders while all other disorders are Axis 1 disorders. The distinction arose with the revised edition of the DSM-III-R to "encourage the consideration of comorbid personality disorders in the context of a more florid or more immediately problematic mood, anxiety or psychotic disorder."

p. 61), this recommendation was refined to state “an effort must be made to improve these conditions [severe psychiatric disorders] with psychotropic medications and/or psychotherapy before surgery is contemplated.”

Individual mental health professionals need to make a value judgment on a client’s need for psychotherapy or perhaps the client may seek this service. The role of psychotherapy is to optimise the trans* person’s quality of life by situating their identity and exploring ways to achieve that. The guidelines state that changes to gender role, identity and expression are implicated in “psychological, social, physical, occupational, financial, and legal ways” (WPATH, 2011a, p. 24) and that the trans* person should be ‘aware’ of what these challenges are ‘likely to be’. The SOC [Version 7] (WPATH, 2011a), however, fail to indicate what challenges trans* people may face throughout the transition process beyond those challenges being described as above. Participants’ accounts in my study suggest that there is a range of issues throughout the transition process to consider such as body image, loss and grief, sexuality, spirituality, social acceptance, legal recognition, other mental health concerns such as anxiety and substance abuse to name a few. The guidelines offer scant information about these issues. The extent of the recognition of these issues in the guidelines (WPATH, 2011a, p. 10) is as follows:

> …purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalised transphobia; enhancing social and peer support; improving body image; or promoting resilience.

My research suggests that there appears to be an assumption that the known long term effectiveness of SRS as an intervention and increased

patient satisfaction with the surgery precludes a thorough explication of the psychological, social, physical, occupational, financial, and legal needs of the individual. The guidelines (WPATH, 2011a) go into great detail on the positive effects of hormonal therapies and surgical outcomes in alleviating gender dysphoria and this is indeed vital information for clinicians and clients alike. It would appear these physical attributes are still considered the most important aspect of the process.

The lack of detail contained within the guidelines on psychosocial processes as detailed in Bockting et al. (2006) *"Counseling and mental health care of for transgender adults and loved ones"*, I suggest, would be a welcome inclusion into the guidelines based upon participants accounts. For example, Irish spoke of her depression postoperatively and the lack of support except for her family and friends. Regret was a concern for Dee Dee prior to the operation because she had read of such cases and she questioned whether that would apply her as well. Ms Mel had no family support her entire life and lived a heteronormative existence in denial of her identity. Daniel had tensions associated with religiously conservative parents not coming to terms with his gender and this situation caused Daniel to internalise his transphobia. Buffy spoke of her long term issues with depression and her inability to come to terms with transition, reverting back and forth between genders over many years.

That is not to say the entire work be relocated, but a reworking of such content to include detail on issues such as "transgender-specific elements" (Bockting et al., 2006, p. 60) including body image, grief and loss, sexual concerns, social isolation, spiritual and religious concerns, substance use,

and violence and abuse would be useful, as well as more detail of the summary of psychotherapy already included.

Exploring communication in the SOC

The findings of this study reflect the view that relationships between health professionals and trans* people, whether those health professionals are psychiatrists, surgeons, endocrinologists, physicians, nurses and so on are important for a fluid transition. Some participants highlighted examples of respectful and disrespectful language in their interactions with health professionals. For example, both LM and Daniel spoke of being misgendered by health professionals in oral and in written communication. On the other hand, Leroy and LM related their positive experiences in the hospital setting in communicating with healthcare professionals. Therefore, communication and language become important issues in navigating transition. However, there is nothing in the SOC [Version 7] (WPATH, 2011a, p. 4) concerned with effective, common-sense communication strategies with trans* people, excluding a comment in relation to terminology in various cultural locations.

The SOC [Version 7] (WPATH, 2011a, p. 28) does include communication strategies on the relationships between mental health professionals and the multidisciplinary team, stating it should be "open and consistent." Several examples throughout the document are concerned with these relationships, such as "regular communication among health professionals…close communication with the patient's primary care provider…communicate as needed with a patient's primary care provider…hormone providers should also communicate with any mental health professional…" (WPATH, 2011a, pp. 30, 41-42, 43). Another example

of communication strategies is concerned with assisting the trans* person in communicating with their wider social networks. Several studies (Ansara & Hegarty, 2013, 2014; Hagen & Galupo, 2014; McLemore, 2015; McNeil et al., 2012; Riggs & Due, 2013) explored and reported how disrespectful language has a detrimental effect on the health and wellbeing of trans* people. Hagen and Galupo (2014, p. 20), in their study of 20 self-identified trans* people, aimed to "discover ways in which patient/provider communication could be improve the health care trans* individuals receive." An analysis of the interview data by Hagen and Galupo (2014) concluded that an improvement in health care could be achieved when health professionals use language that is welcoming and respectful of trans* identities. My study supports those findings. Similarly to issues surrounding psychotherapy and psychosocial issues, my research suggests inclusion of a section on communication into the SOC [Version 7] (WPATH, 2011a).

6.2.7 The regulation of bodies revisited

> *My only regret is maybe not having the surgery sooner. I wish that the medical system wasn't so reliant on initiating testosterone therapy first…I can imagine a completely different world where there is no stigma around wanting to modify parts of our bodies that are considered signifiers of gender. (Jeremy, trans* male, age 29)*

Jeremy highlighted one of the tensions that exists with the regulation of trans* bodies and the inconsistencies that exist in dealing with medical professionals, the DSM-5 (American Psychiatric Association, 2013) and the SOC (WPATH, 2011a). Hormone therapy is not a mandatory prerequisite for surgery (WPATH, 2011a, pp. 34, 104-106). As previously noted, individual clinicians have the capacity to adapt the guidelines to suit individual

circumstances (WPATH, 2011a), or indeed, as suggested by A. Johnson (2015), be ignored altogether. As A. Johnson (2015, p. 807) states, "WPATH's Standards of Care for transgender health are non-binding, and thus non-mandated." The DSM-5 (American Psychiatric Association, 2013), while, less imposing and pathologising than previous versions, still stamps its authority over trans* people pursuing SRS with its need for a psychiatric diagnosis. As stated upfront in the chapter on GD in the DSM-5 (American Psychiatric Association, 2013, p. 451), "there is one overarching diagnosis of gender dysphoria," which according to Harwood and Vick (2012, Governmentality and knowledge/discourse, slide 4), not only governs trans* bodies but makes those bodies an "object of knowledge."

The analysis thus far has highlighted that medical professionals, at the individual level, "hold transgender people [such as Jeremy] accountable to the diagnostic criteria" (A. Johnson, 2015, p. 807), while it is also argued that the SOC (WPATH, 2011a) may be too flexible as a set of guidelines. Yet, the analysis also considered the gatekeeping role of the SOC (WPATH, 2011a) with its insistence on strict eligibility criteria which, in the case of genital SRS, must be sanctioned by two independent psychiatric and/or psychological assessments. These tensions between too much regulation on the one hand, and too much flexibility on the other, suggest an association with the notion of the "*the born in the wrong body"* trope (A. Johnson, 2015, p. 807, emphasis in original) and the inability of trans* people to have the capacity to take control of their own lives. These notions have permeated the trans* experience since the work of Benjamin (1966) and its introduction into the DSM-III (American Psychiatric Association, 1980).

Although the DSM-5 (American Psychiatric Association, 2013, p. 451) "focuses on dysphoria as the clinical problem, not identity per se," it essentially reinforces the dualistic notion of gender through the use of language that typifies such stereotypes. For example, "to be of the *other* gender," "to be treated as the *other* gender," "to be *rid* of one's primary and/or secondary sex characteristics," and so on are the terms in the DSM-5 (American Psychiatric Association, 2013, p. 452, emphasis added) that are guiding clinician's judgements to follow the SOC (WPATH, 2011a) or not. In doing so, as Harwood and Vick (2012) suggest, this approach erases other types of trans* bodies, creating what Harwood (2013) refers to as 'legitimate' and 'illegitimate' bodies. The tension is realised as the SOC (WPATH, 2011a) acknowledges the diversity and fluidity of the trans* population, and the requirement to govern those clients who *need* hormonal and surgical intervention to create a normative existence, despite SRS's overwhelming success rate as a medical and surgical procedure. The DSM-5 (American Psychiatric Association, 2013) supplies the framework to facilitate the governance and legitimise regulation. As argued by Spade (2003, p. 18), "sex reassignment-related procedures are regulated through a mental health model which promotes regulatory, binary gender expression and denies access to medical procedures to those who fail to perform normative binary gender for their health care providers."

6.2.8 Summary and conclusion

To summarise, the discussion around the medical discourse involving SRS recipients has explored how trans* bodies are regulated based upon a psychiatric diagnosis of GD where psychiatrists and psychologists assume

the role of gatekeeper; a role that reinforces the pathological notion of being a trans* person. Although it is perceived in medical circles that a diagnosis of GD is less pathologising than the previous diagnosis of GID as it recognises dysphoria as the point of focus, (American Psychiatric Association, 2013), there still exists the need to accede control to the system and follow a prescriptive checklist to pass through the gate. This approach to assessing and treating a condition where the resultant surgery is still classed as cosmetic surgery further regulates trans* bodies.

There exists a paradoxical situation where cosmetic surgery of the primary and secondary sexual organs where trans* people are concerned is considered a mental illness. However, cisgender people who wish to modify such body parts as breasts, chests and vaginas do so without psychiatric and psychological intervention, creating a perception of 'us and them' which further compounds the notion of social and medical control of trans* people. Additionally, religious or other cultural rituals routinely modify genitalia to satisfy social mores; for example, male and female circumcision. I then turned the discussion to the vulnerability and inappropriateness created through the use and abuse of power at the medical level. Some participants' perceptions suggested a sense of powerlessness, not being supported and feeling humiliated in their interactions with health professionals resulting in social disqualification and deligitimisation. Indeed, the readiness for surgery can be impeded by such approaches as some trans* people feel the need to relate a scripted tale of their suitability for surgery. However, I can conclude that the readiness for surgery depends upon appropriate supply of services to ensure that readiness based upon personal circumstances.

The findings of this research indicate an inconsistent approach by health professionals in providing psychosocial supports. The perception of the participants on support from health professionals ranged along a continuum ranging from disregard, lacking and dismissive to caring, sympathetic, appropriate and welcomed. Just as social and medical supports are important, the use of appropriate communication and language by health practitioners towards trans* people is equally important. As highlighted by Hagen and Galupo (2014, p. 19), gendered language can be problematic and "creates conflict for trans* individuals." Therefore, I can conclude that each case is unique and there is a need for both medical professionals and trans* people to form collaborative relationships. The medical discourse is found in the finer detail of the guidelines for the care of trans* people (WPATH, 2011a). An analysis of those guidelines suggests that while some areas of care are adequately explored, such as the effectiveness, side effects and risks of hormone therapy, and protocols for health professionals, the guidelines are vague concerning issues such as the psychosocial aspects of transition, the lack of focus on communication and the flexibility of the guidelines. This results in tensions with the SOC (WPATH, 2011a), the DSM-5 (American Psychiatric Association, 2013) and individual clinicians actions, which becomes problematic. SRS remains a contentious issue among healthcare professionals and the following words by Billings and Urban (1982, p. 278) would still appear to apply in the current context. "By substituting medical terminology for political discourse, the medical profession has indirectly tamed and transformed a potential wildcat strike at the gender factory." I now turn to participants' experiences with the

legal system in Australia where inconsistencies and contradictions were apparent.

6.3 NAVIGATING THE LEGAL SELF

In exploring the personal self, I introduced the concept of the monster as a biological abnormality in terms of participants experiences as someone with abnormal chromosomal variations or someone who should be thought of as somehow lesser than normal and hidden from view. However, the concept of the monster has wider social implications beyond the personal dimension. Foucault's (2003, pp. 65, 324) words below on the everyday lives of hermaphrodites in the 17th and 18th centuries conveys social control at the highest level:

> The monster was also someone with two sexes…it is only a monster because it is also a legal labyrinth, a violation of and an obstacle to the law, both transgression and undecidability at the level of the law …. what makes a human monster a monster is not only that it is an exception to the form of the species but also that it introduces disorder into the legal system.

Furthermore, according to L. Rogers (1999), biological differences can be used to maintain social inequality and control. The Australian legislative framework with its discriminatory practices is inherently linked to psychosocial processes and experiences as trans* and gender diverse people go about their daily lives; and this can have a direct influence on health and wellbeing based on those personal journeys. Participants' experiences demonstrate that contemporary trans* people in the 21st century occupy spaces that bring disorder to that framework, as Foucault's (2003) words suggest. In order to contextualise how the everyday lives of the participants in my study are impacted by legal systems in Australia, I provide

an overview of the Federal system of government and the various laws therein.

6.3.1 Legislative realities: institutional sexism

The federal system of government: a brief overview

There are multiple layers of government in Australia. The Commonwealth of Australia operates under a federal system of government where powers are divided between the Commonwealth government and the six States. On top of this, there are two Territories on the mainland (Australian Capital Territory and Northern Territory); that is, land not claimed by the States, who have a limited right to self-government. These territories are often seen as States outside of government circles due to their population base. There are also several external territories, such as Norfolk Island, which has limited right to self-government until July 2016. Under Sections 51 and 122 of the Australian Constitution (Commonwealth of Australia Constitution Act, 2003), the Commonwealth Government has the power to pass laws affecting the entire nation. The States also have their own constitutions and pass laws that are not controlled by the central government as laid out in Section 51 of the Constitution. To add to this complexity, Commonwealth, State and Territory jurisdictions pass other laws which fall outside these criteria. Such laws include the various sex, anti-discrimination and equal opportunity Acts around the country and I explore how the participants everyday lives were impacted by inconsistencies in the systems of government and the legislative framework under which they live. These factors contribute to the systemic oppression and social control of

trans* people in Australia and ultimately impede trans* people from getting on with life throughout their transition.

The commonwealth government

When first enacted, the Sex Discrimination Act (1984) conveyed no rights to trans* people. A person's gender or gender identity were unknown entities at the time this piece of legislation was introduced. The legislation assumed the binary nature of sex/gender and was written in terms of men and women. In 2013, the Sex Discrimination Amendment (Sexual Orientation Gender Identity and Intersex Status) Bill was passed. The introduction of this Bill has gone some little way at least to ease the psychosocial burden of trans* people when dealing with the Commonwealth Government and its departments. The Bill offers some measure of protection and recognition. In that legislation, gender identity (along with sexual orientation and intersex status) were recognised as attributes and offered some protection under the law similar to that which already existed in the original 1984 legislation to men and women. Under Part 1 Subsection 4(1) of the Sex Discrimination Amendment (Sexual Orientation Gender Identity and Intersex Status) Bill (2013), gender identity was defined as "the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person (whether by way of medical intervention or not), with or without regard to the person's designated sex at birth."

As previously noted, in July 2013, the Commonwealth introduced guidelines on the recognition of sex and gender to enable consistency at the Commonwealth level in official record keeping (Australian Government, 2013). At this point, Commonwealth government departments and agencies

have until July 2016 to implement those guidelines. This process has already begun and trans* people can change their sex and gender markers in key areas such as health, pensions and taxation on written verification from a medical practitioner that transition is taking place (Australian Government, 2013). That is to say, hormonal and surgical treatments are not necessarily required for these changes to take place. Nonetheless, at the time, there was confusion among trans* networks of the extent of the guidelines for the reason that the wording on the document implied an Australia wide approach (that is to say, it included the States and Territories) as the following personal communication by a trans* advocate indicates. "They changed the wording from 'Australian Government' to 'New Commonwealth Guidelines'. The original media release read as if all Australian Governments were party to this Bill" (K. Noble, personal communication, July 5, 2013).

Similarly, in 2011, the Commonwealth removed the prevailing policy of SRS as a prerequisite for obtaining a passport. According to the Department of Foreign Affairs (2011, para. 4), this administrative change "significantly reduces the administrative burden for sex and gender diverse people who want a passport that reflects their gender and physical appearance." The recognition by the Commonwealth Government of the non-binary nature of gender was a welcome inclusion into the Australian political landscape, but relies upon "issues of medical treatment and practice" (Bennett, 2013, p. 390), where social factors are ignored. The work done by the Commonwealth Government in this area stems from The Australian Human Rights Commission (2009) consultative process with sex and gender diverse people, which made 15 recommendations to government on the legal

recognition of sex in documents and government records. Unfortunately, most of the recommendations were ignored, and in one particular area, the Gillard Labour Government chose to amend legislation to prohibit change. In part, Recommendation 13 (Australian Human Rights Commission, 2009, p. 4) states:

> …amend the *Sex Discrimination Act 1984* (Cth) to ensure that the protection against marital status discrimination applies in the context of married persons seeking to amend their birth certificates, to effectively override the existing discrimination under state and territory births registration legislation.

Indeed, the Commonwealth Government did amend the above mentioned legislation. Prior to the introduction of this legislation (Sex Discrimination Amendment (Sexual Orientation Gender Identity and Intersex Status) Bill, 2013) and these guidelines (Australian Government, 2013; Department of Foreign Affairs and Trade, 2011), the Commonwealth effectively gave the States and Territories the power to discriminate against trans* people when it introduced and passed the Sex and Age Discrimination Legislation Amendment Bill (2011). Under Section 40(5) of that Bill, the States and Territories were given an exemption to "refuse to make, issue or alter an official record of a person's sex if a law of a State or Territory requires the refusal because the person is married."

This exemption effectively excluded all trans* people who were legally married under the Marriage Act (1961), which is Commonwealth legislation, and wished to remain married, from changing their gender marker to recognise their change in status as a postoperative trans* person if the States and Territories deemed it so. Additionally, one can interpret that it

would seem to give some type of precedence to the introduction of same sex marriages if trans* people could change their gender marker and remain married. The complexity and the inconsistency of the phenomenon is compounded by the extent of legislation that exists at State and Territory level of government for the reason that most of the States and Territories also have their own versions of the Sex Discrimination Act (1984), all of which have varying degrees of protection.

The state and territory governments

In summary, the States and Territories have 10 separate pieces of anti-discrimination legislation which can and do impact upon the everyday lives of trans* people.[84] However, there is no consensus on their approaches to the area of anti-discrimination legislation. In three jurisdictions, South Australia (Equal Opportunity Act, 1984), the ACT (Discrimination Act, 1991) and Victoria (Equal Opportunity (Gender Identity and Sexual Orientation) Act, 2000; Equal Opportunity Act, 1995), it is unlawful to discriminate on the grounds of gender identity. The definition of gender identity in these instances is considered broad enough to include both medical intervention and/or social circumstances as an appropriate basis to identify as a person of another gender.

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[84] Equal opportunity, and anti-discrimination legislation includes:

- Equal Opportunity Act 1984 (SA)
- Equal Opportunity Act 1995 (Vic)
- Equal Opportunity (Gender Identity and Sexual Orientation) Act 2000 (Vic)
- Discrimination Act 1991 (ACT)
- Anti-Discrimination Act 1977 (NSW)
- Transgender (Anti-Discrimination and Other Acts Amendment) Act 1996 (NSW)
- Anti-Discrimination Act 1991 (Qld)
- Equal Opportunity Act 1984 (WA)
- Anti-Discrimination Act 1992 (NT)
- Anti-Discrimination Act 1998 (Tas)

For example, in Victoria, under Part 1 4(1) of the (Equal Opportunity Act, 1995), gender identity means:

> (a) the identification on a bona fide basis by a person of one sex as a member of the other sex (whether or not the person is recognised as such)—
> (i) by assuming characteristics of the other sex, whether by means of medical intervention, style of dressing or otherwise; or
> (ii) by living, or seeking to live, as a member of the other sex

In Western Australia (Equal Opportunity Act, 1984), protection is given on the grounds of gender history and only to those who have been gender reassigned, which is defined as someone who has been issued with a Gender Recognition Certificate under the Gender Reassignment Act (2000). In Western Australia, under Part IIAA, Section 35AA(1) of the Equal Opportunity Act (1984), gender history refers to identifying and living or seeking to live in the opposite sex, where opposite sex is interpreted as not the birth sex.

In Queensland's Anti-Discrimination Act (1991), gender identity means that you identify as and must live or seek to live as a member of the opposite sex. In New South Wales, the Transgender (Anti-Discrimination and Other Acts Amendment) Act (1996) offers protection to a transgender person by living, seeking to live or identifying as a member of the opposite sex, and being thought of as a transgender person regardless of being considered a recognised transgender person. According to Part 1(4) of the Anti-Discrimination Act (1977), a "**recognised transgender person** means a person the record of whose sex is altered under Part 5a of the *Births, Deaths and Marriages Registration Act 1995* or under the corresponding provisions of a law of another Australian jurisdiction."

That is to say, being thought of as a transgender person may reflect the present or former social status of that person. In the Northern Territory, the Anti-Discrimination Act (2011), sexuality is protected. Under Part 1(4) of the Act, sexuality is defined as "the sexual characteristics or imputed sexual characteristics of heterosexuality, homosexuality, bisexuality or transsexuality." Similarly, Tasmania considers transsexuality to be aligned with sexual orientation and is not expressly protected. Norfolk Island does not have any anti-discrimination legislation. Appendix U summarises the legislative criteria for the States, Territories and the Commonwealth Governments in reference to the various sex, equal opportunity and discrimination. This diagrammatic representation highlights the inconsistencies of the various legislations that impact upon trans* people. When the Commonwealth government enacted the Sex Discrimination Amendment (Sexual Orientation Gender Identity and Intersex Status) Bill (2013), the States were "given until July 2014 to ensure that all state laws were amended to be consistent with the new federal provisions" (Australian Human Rights Commission, 2015, p. 71). That deadline was extended until July 2015, and as yet has been ignored. In addition to the confusion and inconsistency in these pieces of legislation, each State and Territory has separate legislation for the changing gender markers on official records.[85]

[85] Legislation to change gender markers include:

- Births, Deaths and Marriages Registration Act 1997 (ACT)
- Births, Deaths and Marriages Registration Amendment Act 2014 (ACT)
- Births, Deaths and Marriages Registration Act 2003 (Qld)
- Births, Deaths and Marriages Registration Act 1999 (Tas)
- Births, Deaths and Marriages Registration Act 1996 (Vic)
- Births, Deaths and Marriages Registration Act 1995 NSW)
- Births, Deaths and Marriages Registration Act 1996 (NT)
- Registration of Births Deaths and Marriages Act 1963 (NF)

New South Wales, Northern Territory, Tasmania, Victoria, Norfolk Island and Queensland have a definitive approach which stipulates SRS, defined essentially as the surgical removal or alteration of reproductive organs is required to change your gender marker (Births Deaths and Marriages Registration Act, 1995, 1996, 1999, 2003; Registration of Births Deaths and Marriages Act, 1963). Interestingly, in Norfolk Island, Section 23B (2) of the Act notes:

> Where the Registrar is satisfied that the reassignment procedure has occurred, then if the applicant does not wish to be assigned as being male or female but of non-specific sex, the Registrar must accept that decision of the applicant (*NSW Registrar of Births, Deaths and Marriages v Norrie:* High Court of Australia 2014*).*

The decision by the High Court of Australia (2011) allows applicants to have no gender marker noted on their certificate; another layer of inconsistency for trans* people to contend with. Both South Australia and Western Australia have legislation specifically for gender reassignment and are similar in definition of their requirements (Gender Reassignment Act, 2000; Sexual Reassignment Act, 1988). Under Part 1(3) of the Sexual Reassignment Act (1988), reassignment in adults is interpreted as:

> …a medical or surgical procedure (or a combination of such procedures) to alter the genitals and other sexual characteristics of a person, identified by birth certificate as male or female, so that the person will be identified as a person of the opposite sex…

In the Gender Reassignment Act (2000) in Western Australia, substitute 'gender' for 'sex'. According to Bennett (2013, p. 387), the latter was "highly

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- Sexual Reassignment Act 1988 (SA)
- Gender Reassignment Act 2000 (WA)

influenced by the *Sexual Reassignment Act 1988* (SA) that they share identical wording in certain sections because parts of the earlier Act were copied wholesale into the later Act." The level of inconsistency is expected to gain further momentum in South Australia while its parliament considers changing some of their highly scripted legislation to remove the requirement for SRS recipients to be single to obtain a Gender Recognition Certificate (Sexual Reassignment (Recognition Certificates) Amendment Bill, 2014). In contrast, in the ACT, diversity of sex and gender is reflected in their legislation (Births Deaths and Marriages Registration Act, 1997; Births Deaths and Marriages Registration Amendment Act, 2014). Under Section 24(1)(c) of the Births Deaths and Marriages Registration Amendment Act (2014), the requirement of SRS adopted by other states (whether that be medical and/or surgical alteration), was removed and replaced with:

> the person believes their sex to be the sex nominated in the application (the ***altered sex***), and—
> (i) has received appropriate clinical treatment for alteration of the person's sex; or
> (ii) is an intersex person.

In addition, all jurisdictions except for the ACT require the person to be unmarried, which is interesting in that same sex marriage legislation in Australia is non-existent. So therefore, in the ACT, I could be married, have SRS, remain married, change my gender marker and be part of a same sex marriage which is not recognised under Australian law; an interesting concept to navigate socially and politically. The ACT legislation, the Births Deaths and Marriages Registration Amendment Act (2014) remains the most progressive in Australia twofold; by recognising that SRS is an unnecessary

legal and social impediment for trans* people in that jurisdiction to navigate their daily lives. Equally important, it gives those trans* people who wish to remain married following SRS to do so and to change their gender markers to recognise their change in gendered status. Although it is socially progressive, it still lacks the capacity to recognise those trans* people born overseas who, following SRS, wish to change their gender markers, thereby leaving another legal black hole to navigate.

Many governments around the world use legislation to enforce the surgical sterilisation of trans* individuals in order to change gender markers, and some jurisdictions in Australia are a party to this discriminatory practice, as evidenced by the previous discussion. This wholesale approach to recognising a person's identity has been opposed by WPATH for more than half a decade (2010). In that statement, WPATH (2010, para. 2) urged all governments to remove such legislation to allow trans* and intersex people the right to identify themselves in a way that endorsed their lived identity, "regardless of reproductive capacity." To do so would remove some of the psychosocial burden that trans* people endure in their everyday existence. More recently, WPATH (2015) further developed that statement as some jurisdictions in the world, including Australia, require medical professionals to become signatories for legal cases on the status of trans* individuals. Issues surrounding vulnerability, discrimination, violence and social transition are affected by such discriminatory laws and social practices. Practices such as the ones defined at the institutional level that affect the health and wellbeing of trans* people exist "because it is the result of social structures and norms that exist independently of the individual, it is chronic and is socially

conditioned" (Jokić-Begić et al., 2014, p. 1). I now turn to the participants' experiences of the legalities of changing "sex" and "gender" and their impacts upon daily life for trans* people in this study.

6.3.2 'Normal' life gets in the way of me being me

The trans* people in this study come from all walks of life; city folk, country folk, straight, gay, single, married, young and old and so on. They all have one thing in common, though, and that is they are trans* people. Therein lies the problem. Occupying a space as this biological abnormality creates identities that do not conform to societal norms in areas covering a broad range of legal and administrative formalities such as changing names on documentation, gender markers on birth certificates and other official records. Additionally, it places some trans* people in a space where transition no longer becomes a seamless, fluid operation for the reason that unexpected life circumstances and the realities of daily life highlight the legal system's rigidity.

> *I couldn't change my name legally until about 4 weeks before I had the operation because my wife had been killed in a car crash and I was appointed by the solicitor to operate the will. The emotional side of it really was the fact that, could I change my documents? The other thing was how did it affect the situation? I couldn't go and change all of the 40 odd pieces of documentation that I had because I wasn't legally Irish, and that was one hell of a dash afterwards. (Irish, female, age 78)*

The reality of living in the here and now becomes problematic when "its continuity is interrupted by the appearance of a problem" (Berger & Luckmann, 1966, p. 24). At a personal level, for Irish, the timing of these two major life events placed her in a legal limbo over which she had no control. Her experience suggests powerlessness to create the changes necessary for

a smooth transition based upon an entire life of heteronormative manhood or womanhood, marriage, death of a spouse and all that that entails. Therefore, life's continuity is distorted by the need to remain conformed to a previous reality at a time when immense life changes are imminent. Irish's account implies another period of waiting (Vitale, 2010) as the physicality of the preoperative trans* body and the legal requirements of society affects every day experiences.

The fear of dying and strong family commitments also brings about its own concerns about the legal consequences of gender transition, as the following account relates:

> *I've got super[annuation] and I've got insurance in super[annuation] as well. For if I died, I'd get a big enough sum of money for him [disabled son] to get the care that he needs if I'm no longer here, and I can just see if I die, what comes through on my death certificate? It's from Births Deaths and Marriages. It will be 'female'. What is my superannuation? Apparently I've left it all female so they bloody well match because I see if I change one, and not the other, they probably won't pay out that money because there's good enough reason for them to hold it saying this isn't the same person. (Andrew E, male, age 48)*

Here, the perception of immutable legal contracts constrains Andrew E's personal freedom to totally immerse himself in his male embodiment despite having undergone SRS. It suggests that the personal self is constantly reminded of the vestiges of heteronormativity brought about by a legal fall out by having conflicting documentation needed for daily life events. For Berger and Luckmann (1966), it is social institutions such as these that control our behaviour and conduct by the nature of their authority and our acceptance of it. Thoughts of a future beyond the finite line which is death are constructed around intimate familial relationships and the need to secure

that future. As Ricoeur (1992, p. 161) states "…the life history of each of us is caught up in the histories of others." In contrast to Irish, who was awaiting SRS, Andrew E had already undergone SRS, and he was not in a position to change his documentation. It was an historical artefact and it became an impediment to moving forward based upon those personally perceived and institutionally imposed legalities. Other instances occur when not wanting to change documentation is motivated by fear of personal and social consequences, as the following participant states.

> *I feel awkward about changing it [birth certificate] too. It's actually important to me to have some kind of visible recognition of being trans* but I feel conflicted about that because we don't have sufficient anti-discrimination protections in place. Yes so there's legal limbo in that I've chosen not to change my birth certificate despite the recent change to the scenario in Western Australia. I don't want to put male on my certificate. That's not what I was assigned at birth and I'm comfortable being a trans* person. (Jeremy, trans* male, age 29)*

Jeremy recognises himself as a non-binary trans* person and explains a notion of gender that refutes the view that gender is tied to a binary framework, as Berger and Luckmann (1966) assume. Recognition of assigned birth status could be perceived as betraying your personal identity. Nonetheless, there remains the undeniable reality that the vast majority of trans* people who undergo SRS are biologically assigned in a 'sex' that mismatches their psyche. This account, while suggesting the fluidity of the trans* phenomenon also suggests a breakaway from imposed social control of identity by taking personal ownership of embodiment, as Featherstone (1999) argues. In other words, Jeremy's embodiment brings with it perceptions of the hybridity of the monster at the personal and social levels, as Derrida (1995, p. 385) contends:

> But the notion of the monster is rather difficult to deal with, to get a hold on, to stabilize. A monster may be obviously a composite figure of heterogeneous organisms that are grafted onto each other. This graft, this hybridization, this composition that puts heterogeneous bodies together may be called a monster.

This ownership of identity can bring with it hybridity at the legal level with its mismatch in documentation, creating further complications for trans* people born overseas, as the following account relates.

> *In the Netherlands, where I hold a dual citizenship, I'm considered female and they have the same rules about hysterectomy so if I change my gender here in Australia, I'd be simultaneously a Dutch woman and an Australian man, legally speaking, which is just bizarre, so my EU passport would say female, and my Australian says male. (Jeremy, trans* male, age 29)*

Contextually, this places some trans* people in a legal black hole and possibly in a dangerous space when the same person essentially has two identities based upon the conflicting legalities of two mutually exclusive social institutions. The perception of living socially and surgically as a masculine entity contradicts the legal realities imposed by these social institutions. As Foucault (2003, p. 324) argues, "at the forefront of these ambiguities is the never wholly mastered interplay between the exception of nature and the breach of the law." It is just not those ambiguities with having mismatching passport documentation; the social and physical presentation of some trans* people also becomes problematic when travelling overseas, as the following account relates:

> *My passport reads male. I wanted to put 'X', but pragmatically chose male because I was detained at LA Airport in 2010 because of the anomaly – the passport at that point said female, and they didn't believe I was a woman, so I was detained for a few hours and got investigated about that. I thought, that went relatively without incident although it was a bit scary being detained but I would really love to*

> *travel to places where I know it's a problem, and I don't want to have to draw attention to myself so an 'X' passport would probably draw attention to myself. So it's purely pragmatic putting 'M' on my passport. (Jeremy, trans* male, age 29)*

The reality of this issue becomes more problematic when there is a mismatch with other cardinal documents such as birth certificates. Many trans*people who pursue SRS go overseas for their surgery. Trans*men such as several participants in this study have no other option as bottom surgery (besides hysterectomy) is not available in Australia. Being in a foreign country with two sets of documentation, one saying you are male and the other saying you are female can lead to unforeseen consequences if detained. Airlines around the world have a '*no fly'* policy if documentation is conflicting. For example, Virgin Australia (n.d.), in their Conditions of Carriage 6.4(c) state "you will not be entitled to be carried on a flight unless you provide positive valid, satisfactory identification and a valid Electronic Ticket has been duly issued in the same name." Other ports of entry may deport trans* people in these circumstances back to Australia or be detained for indeterminate amounts of time.

These ambiguities between nature and the law are seen in the everyday experiences of going about 'normal life', where unnecessary discriminatory practices are played out, as one trans* woman stated:

> *I'd had an experience where I'd been pulled over in their [employer] van because it turned out that their van wasn't registered, which is why I only lasted there 2 days, but the cops were calling me 'sir', and look it was really hard to say "no look you're just being an asshole" because they'd taken my driver's licence; they'd gone and checked the details and it was Mr. But I was kind of relieved that once I got my birth certificate changed I could go to Vic Roads to get my licence changed. (Buffy Dunlop, female, age 44)*

The imbalance of this power dynamic is defined by a mismatch in Buffy's identity and the law; the displays of such discriminatory practices are bound up in society's institutional hierarchy. Berger and Luckmann (1966, pp. 108-109) describe this imposition of reality as legitimised and "related to the power by those who operate them…he who has the bigger stick has a better chance of imposing his definitions of reality." These accounts are a reiteration of the problematic reality (Berger & Luckmann, 1966) which I suggest is a common thread for trans* people in everyday life.

6.3.3 Legal impracticalities and inconsistencies: personal perspectives

From the previous discussion, it is evident that one area of contention is the changing of documentation and in particular, gender markers to match identity. Australia is no different to other societies such as the United States (Spade, 2008, 2011). Changing documentation continues to be a concern for many trans* people as was highlighted by the Australian Human Rights Commission (2009) and a study by Couch, Pitts, Croy, Mulcare, and Mitchell (2008) concerned with transgender recognition and citizenship. It is now almost a decade since this research and it would appear that little has changed in the ensuing years. Some trans* people in my study do not actually bother to attempt the change because of the perception that there are too many barriers to surmount, while others somehow go around the system and get their records changed when not really entitled to it under State and Territory law. More broadly, outside of my study, other trans* people have challenged the law and won (AB v. State of Western Australia & Anor, 2011; AH v. State of Western Australia & Anor, 2011; NSW Registrar of Births Deaths and Marriages v. Norrie, 2014). It is the States and Territories

that administer this area, and it is the lack of consistency in legislative requirements at State and Territory level, based on different laws, that impose unnecessary complications on trans* people. One trans* man relates his difficulties with the system.

> *The birth certificate is absolutely diabolically hideous in Victoria. I'm led to believe that we are the worst state. It's almost impossible for some of us to get it changed. The rules inside the office state if I can quote almost correctly that you have to have undergone surgery to your reproductive organs for the purpose of passing as the other gender. That works for trans* women because it is the trans* women's surgery of the genitals. The trouble is what men want…trans* men is your tits off for the purposes of passing but they are not your reproductive organs…if you had a hysterectomy and didn't have your tits off, you're not going to look any more like a man. (Andrew E, male, age 48)*

Andrew E's account demonstrates an inconsistency in the way in which trans* men are treated in comparison to trans* women in that jurisdiction. The Victorian Births Deaths and Marriages Registration Act (1996)[86] recognises transsexualism under Part 4A of the Act. However, to qualify for a change in gender marker to the preferred gender, proof of 'sex affirmation surgery' is required. Under Section 4.1 of the Act, sex affirmation surgery is defined as "…a surgical procedure involving the alteration of a person's reproductive organs carried out for the purpose of assisting the person to be considered to be a member of the opposite sex."

This law effectively excludes all trans* men who have not had 'bottom' surgery including hysterectomy, oophorectomy, metoidioplasty or phalloplasty from changing their gender markers. However, one can argue that to be "considered to be a member of the opposite sex," primarily, for

[86] Similar legislation exists in relation to the removal or alteration of reproductive organs in New South Wales, Northern Territory, Tasmania and Queensland.

trans* men, it is 'top' surgery, as previously discussed that is the most defining feature of their masculinity and social appearance as the 'opposite' sex. It is argued here that this legislation stems from the misconception that SRS is the realm of trans* women given their higher public exposure during the 20th century and highlights the relative ease of changing documentation for trans* women. However, a further account from a Victorian participant highlights another inconsistency when proof of 'sex affirmation surgery' is not just determined by a definition under the Act, but the medical verification of the surgery and, in this particular case, where entitlement to new documentation is not legally warranted.

> *But the form that you fill out doesn't actually make you specify what surgery you've had. And then you just need 2 doctors, so I got my doctor and my psychiatrist to fill out a form saying that I'd done it, so I have a male birth certificate then but I'm not really entitled to it. I mean by that law I could not take testosterone, have boobs and just get a hysterectomy and I could change it. That's just ridiculous! Look at me! (LM, male, age 27)*

Similarly, another trans* man living in New South Wales noted the relative ease of changing gender markers in that State with the conflation between medicine and the law.

> *…to change your gender, you just download a Stat[utory] Dec[laration] online and you get your GP or just anyone – a health professional, and your surgeon to just fill that out and that's it…you just send it off and they change it. It was really easy. (Leroy, male, age 31)*

Based upon the self-reported surgical status of these participants, the right to legally change documentation was not sanctioned for the reason that neither qualified under Part 5A(32A) of the New South Wales Births Deaths and Marriages Registration Act (1995) with its definition of 'sex affirmation

procedure' in congruence with its Victorian (Births Deaths and Marriages Registration Act, 1996) counterpart. Alternatively, the attitudes of some public servants administering these procedures can affect day to day life and the ability to change gender markers, as the following account relates.

> *I think New South Wales is quite lucky in that regard [birth certificate]. Yeah, well there seems to be some good people working in Births Deaths and Marriages…in fact, a particular guy there who I think I encountered a couple of times who seems like he's allowing that to go through without scrutinising it too much which is good. (Jimmy, male, age 33)*

These inconsistencies, as experienced by these participants, and the different approaches taken by medical practitioners and public servants in the process is summed up in the words of Bennett (2013, p. 392):

> Drawing legal focus away from the transsexual person and placing importance on the opinions and reactions of other people relatively devalues the importance of that transsexual person's subjective experience and exposes the success of their legal claim to the whims of those around them.

The legislative framework and its potential to impede personal identity development is further highlighted when one cannot legally change gender markers despite undergoing SRS. This problem was identified by an SRS recipient who is legally married and wishes to remain so following SRS:

> *I still have a problem with my birth certificate and that really concerns me…they won't let me change my birth certificate to say I am a female because I refuse to get divorced. Why should we get divorced to satisfy the bureaucrats in Births Deaths and Marriages [Queensland] when we still love each other and intend to stay together as a couple? (Dee Dee, trans* woman, age 49)*

This situation is psychosocially burdensome for the reason that it denies married trans* people such as Dee Dee the ability to identify with the gender

that, for all other legal and every day purposes, is recognised as their preferred gender. Temporally, it enforces a reversion to a previous embodiment, which goes beyond the waiting game as argued by Vitale (2010). Indeed, this experience can be interpreted as being stuck in a time that, according to Bennett (2013, p. 380), "could lead to the undermining of the importance of transsexuals' own psychological sex identifications and subjective experiences…and the requirement that they conform to narrow, stereotypical models of sex."

These problems associated with inconsistent attitudes towards legislating changing gender markers for trans* men and women in Victoria, New South Wales, Queensland, Northern Territory and Tasmania goes beyond changing gender markers, where undergoing SRS is legislated, as the following account indicates:

> *The South Australian system is a law unto themselves. It is actually an Act there. There is an Act of parliament that says this is how you can transition, so it's quite prescriptive, so like it or not, that's the way it is but I guess it could be changed and at least it did get me my Gender Recognition Certificate which I wouldn't have managed to get out of Victoria any other way probably. (Jim, male, age 32)*

Similarly, Western Australia has legislation and is perceived by one participant to be controversial based upon High Court rulings as previously described.

> *Yeah – that's a minefield! The main legal things I faced were being born in Western Australia where change of gender legally – change of birth certificate till very recently due to the contested court challenge in the High Court, you were required to have had a hysterectomy, so I couldn't legally change my gender there. (Jeremy, trans* male, age 29)*

Both Western Australia and South Australia take the social control of trans* people in those jurisdictions to a different level through tightly scripted legislation (Gender Reassignment Act, 2000; Sexual Reassignment Act, 1988). Participants' accounts of changing such documentation suggest that is not just the changing of these official records that is the issue; it is the underlying systemic discrimination and inconsistency in administration that continue to flourish based upon the inconsistencies in the systems at State and Federal level. However, further discrimination exists at the Commonwealth level, where some trans* people are placed in a position of privilege.

6.3.4 The rite of passage for some: trans* privilege

However, in Australia there exists another layer of discriminatory practice embedded in what I refer to as the notion of trans* privilege. Trans* privilege exists where one section of the trans* community are bestowed social, medical and political privilege based upon the existing Commonwealth laws of the land. That section of the community are trans* people in the Australian Defence Forces (ADF) (Department of Defence, 2011, p. 4), where there are administrative guidelines for the management of transitioning individuals with a sensitive and personalised approach. From a legal perspective, the Department of Defence (2011, p. 4) utilises this literal compliance of Commonwealth legislation as stated below:

> Defence must comply with the Australian Human Rights and Equal Opportunities Commission Act 1986, Privacy Act 1988, Sex Discrimination Act 1982, Occupational Health and Safety Act 1991, Public Service Act 1999, and other Commonwealth, State and Territory anti-discrimination legislation. DI(G) PERS 50-1 – Equity and Diversity in the Australian Defence Force and DPI 1/2001 – Equity and Diversity in the Department of Defence require that all Defence

> people should be treated with respect, fairness and without harassment.

For the Department, from the above words, there are no grey areas or any type of political discussion when dealing with transitioning individuals in the ADF. An analysis of this construction would indicate that obeying commands is the mission of the ADF. In particular, the defence value of loyalty (Department of Defence, n.d., para. 2) is explicit in its terminology when it states "we treat everyone at all levels with respect, care and compassion." These guidelines (Department of Defence, 2011), although not official policy, detail the administrative approach on a range of issues including but not limited to posting action, uniforms, change of name, ablutions, family assistance and so on. Another area of consideration is the provision of healthcare services. From a health care perspective, transitioning individuals in the ADF receive health care "for a range of health conditions and is funded by Defence in accordance with the provisions of DI(G) PERS 16-1 – *The Provision of Health Care to Defence Members*" (Department of Defence, 2011, p. 10). It is unclear what services they are entitled to, although the guidelines imply that cosmetic surgery is a grey area. A detailed flow chart of the administration of trans* people in the ADF is located at Appendix W.

From this analysis, there is a contradictory juxtaposition in the way in which the Commonwealth Government administers its relationship with trans* people. By affording the members of the ADF a rite of passage to make those necessary changes to their social and corporeal being, effectively places increased psychosocial burden on those trans* people experiencing

civilian life who cannot obtain adequate care and support for their needs. Simultaneously, it removes a sense of citizenship and belonging for the majority of trans* people who aren't afforded such privilege. In effect, they have been institutionally erased (Namaste, 2000); made invisible. As this research has demonstrated, some trans* people struggle with issues on a daily basis without the desired supports in place. It is notable that the ADF is a responsible employer and identifies that GD is a recognised medical condition, however it is demeaning and pays nothing but lip service to the rest of the trans* community. The end result is that there exists a two tiered approach for the trans* community; an unacceptable and confusing outcome occupied by monsters that bring further disarray to the legislative frameworks in this country.

6.4 SUMMARY AND CONCLUSION

This chapter focused on the analysis of the medical and legal selves. In the first instance, the discussion centred on the participants' experiences with the healthcare system, where the findings suggest that trans* bodies are regulated based upon a diagnosis of gender dysphoria, where the onus is on trans* individuals to convince others of the veracity of their claims. The notion of the gatekeeper continues to play a role in the surgical performance and the behaviors of trans* people are scrutinised from a position of power and knowledge. Throughout this discourse, levels of psychosocial support prior to, during and beyond SRS varied from inappropriate and unsupportive to welcomed and supportive. The doctor-patient relationship was questioned and some participants felt socially disqualified in a one sided power dynamic.

Furthermore, surgical readiness was questioned. Some participants, although personally ready for the surgery, felt further support was appropriate to navigate the surgical process, while others perceived that they were unsupported, which increased their psychosocial distress. On the other hand, some participants felt supported throughout the process. The language and bed-side manner of health professionals was seen as problematic by some participants, which delegitimised their identities and contributed to the continued medical pathologisation of those identities. It is argued that meeting the needs of trans* people pursuing surgery is a challenging process as is navigating the system, and can be a challenging process. The participants' experiences highlighted the difficulties they faced dealing with the healthcare system while satisfying the criteria of the SOC. An analysis of the guidelines indicated possible enhancements in relation to communication and psychosocial issues.

Alongside the medical dimension, the legal self presented more challenges for the participants in this study with 10 governments; federal, state and territorial inconsistently applying anti-discrimination and births, deaths and marriages legislation. Additionally, it revealed a two tier system whereby some members of the trans* community are treated more favourably than others, based upon an interpretation of the existing laws at the Commonwealth level, which does nothing more than further discriminate against an already marginalised group.

Chapter 7: Conclusions: making sense of a way forward

> *And focus it [education and training] on what people need to know…at least for the medical profession from a curriculum perspective not making it about treatment. Yes that's important for people to know about but it's much important they know how to treat us respectfully because that is universal across whatever field you're in. (Jim, male, age 32)*

7.1 INTRODUCTION

Jim's words above typify the hope of a more informed future; not just for those trans* people whose embodied dysphoria needs bodily modifications through surgical intervention to align the innermost perceptions of self, but for all trans* people. The experiences of trans* people are embedded in their interactions with those around them, and social contact with healthcare providers is a necessary part of their everyday life. It makes sense that healthcare providers; doctors, nurses, psychiatrists and so on need appropriate knowledge to treat trans* people with respect as Jim suggests, to enable trans* people to be supported through the transition process.

This research explored the everyday life experiences of SRS recipients from a whole of life perspective of the self and in doing so has sought to address the need to expand the current and historical research literature in an area that has primarily focused upon the surgical process as a means towards functional, sexual and aesthetic satisfaction from a biomedical perspective (see for example Benjamin, 1966; Castellano et al., 2015; Collyer & Heal, 2002; de Cuypere et al., 2005; Eldh et al., 1997). While functionality

and aesthetics *may* be important aspects of the trajectory of some SRS recipients, this research was not concerned with those particular attributes. Instead, it sought to understand how trans* people navigated the 'change' and if their needs were met in doing so. As a result, this thesis supports an argument for change and, as such, the challenge for trans* people, healthcare providers and governments alike has been set. The formation of collaborative relationships at the biomedical level may go some way in reducing the pervasive notion of the gatekeeper, and the simplification of outdated legislative requirements would ease the psychosocial burden of trans* people in their day-to-day existence to allow a fluid transition.

The key findings of this study were mixed across all four narrative concepts of self. The analysis is indicative of the multiplicity of reality as perceived and experienced by the participants and the interplay between their social experience and the knowledge and meaning created. The ways in which those realities shaped this thesis and the processes which contributed to understanding are as follows:

Personal self

The thesis has portrayed gender and sex reassignment at its messiest. SRS was a fundamental and universal turning point; however, it further challenged the notion of the binary framework of gender into neat compartments of male and female. The innocence of childhood formed notions outside that framework in ways that sometimes appeared socially acceptable, and this [non]acceptability was drawn along gendered lines. However, this didn't further compartmentalise the notion of gender into binary categories. It blurred the lines of what it means to be masculine and/or

feminine, and in some ways, being stuck in a genderless state of existence. Likewise, the notion of SRS as a universally euphoric outcome was also challenged along gendered lines. The body 'works in progress' associated with the complexities of trans* manhood compared to trans* womanhood suggested the creation of a new form of masculinity not associated with the traditional gendered stereotypes of manhood. New forms of femininity could also be seen to exist. This blurring of gender roles, in turn, become embodied extensions of our personhood and further challenges the orthodox binary notions of gender, despite having had SRS. The language of sex reassignment assumes the 'opposite' gender (in medical, legal and societal terms). Whereas, in personal terms, SRS was uniquely experienced in ways that could be described as binary, non-binary, neither or both.

Social self

While the personal complexities of SRS blurred the binary notion of gender, social relationships contributed to the complexity of the experience. Apart from being a challenging process for SRS recipients, transitioning and SRS remained equally challenging for familial and wider social networks as social acceptance further blurred the lines of gender. How trans* gender is constructed calls into question the binary gender framework; the cultural and historical social acceptability of patriarchy was seen to favour gender questioning girls. Beyond the notion of gender, the views of the participants demonstrated that knowledge acquisition about changing gender and social supports at the familial level were equally messy. The levels of instrumental and emotional support were negotiated along a continuum of acceptance/non-acceptance. Those levels of support and acceptance were

sometimes associated with loss and grief throughout various stages of transition, but more specifically postoperatively as social networks came to terms (or not) with new embodiments. Tensions were also highlighted in relation to traditional conservative family values such as religion, which appeared problematic and situated some trans* people on the outside of acceptance. The cultural integrity of the family was also questioned through secrecy; the concepts of stigmatisation and coming to terms with taboo topics by families in their own social worlds were perceived as unnecessary impediments to social acceptability.

Medical self

The analysis demonstrated the inconsistent and almost fragmented ways in which trans* people are challenged as they access necessary medical treatments and how the biomedical model framed that access. The fragmented tension is realised as trans* bodies become regulated, over-regulated and under-regulated. The biomedical discourse shaped the trajectories of the SRS recipients with the interplay between the SOC (WPATH, 2011a), the DSM-5 (American Psychiatric Association, 2013) and the individual approaches of clinicians in the field leaving some participants feeling powerless in their own healthcare as they justified their need for SRS. It appeared that the inconsistencies occurred at several levels of care throughout the transition process resulting in care that was perceived as supportive, intrusive, positive, confusing, neglectful, lacking, dismissive, sympathetic, caring, appropriate but necessary to meet the 'gatekeeping' needs of the biomedical model.

Legal self

Beyond the personal, social and medical messiness portrayed so far, the analysis provided understanding of the regulation of trans* identities where the rigid legislative requirements of 10 governments and more than 20 separate pieces of conflicting legislation exert control over and construct those identities. It also highlighted the tensions that exist when legislation relies on surgical procedures, inconsistent bureaucratic approaches to administering the legislation and the leniency of some health professionals in interpreting the legislation. These inconsistencies echo the findings relevant to the health system with its regulation, over-regulation and under-regulation. Equally, the deligitimisation of trans* men's bodies through a legal lens was highlighted as the complexity of their bottom surgeries are a mismatch to those rigid legal requirements. Such legislative rigidity was shown to impede personal identity development since legal definitions of SRS in the Australian context are in contradiction to global medical definitions. The various legislations were considered outdated and I drew this conclusion from the viewpoint that trans* women of the 20th century were the catalysts of such legislation. In the sections that follow I am concerned with tying the narrative threads together with respect to the key findings through a synthesis of them in terms of the literature and the theoretical and methodological assumptions underpinning this research.

7.2 SRS: A LOOK BACK OVER TIME

As argued in Chapters 1 and 2, current and historical literature situates SRS as a surgical procedure firmly located in the biomedical sphere as both

a medical condition and a mental disease to be treated and controlled. Earliest accounts of SRS in the modern era discussed the use of psychoanalytic tools such as “the hypnoid and word-association method” (Gilbert, 1920, p. 297) which were “unusually successful in disclosing the underlying cause” (Gilbert, 1920, p. 297). From this earliest known case in Western culture in the modern era, trans* narratives continued to be engulfed by the dominant biomedical discourse. By the middle of the 20th century, wanting to change ‘sex’ was viewed as a mental ‘deficiency’ (Cauldwell, 1949), possibly due to a “severely sex-hating psychosis” (Cauldwell, 1951/2001, p. 7) and anyone displaying such tendencies became known as the *“psychopathic transsexual”* (Cauldwell, 1949, p. 275, emphasis in original).

According to Kleinman and Hall-Clifford (2010, p. 250), “biomedicine is shaped by the cultures in which it is practiced.” Biomedical literature throughout the latter half of the 20th century consolidated the social construction of transsexualism as pathological. Accordingly, trans* people needing SRS were labelled as “true transsexual[s]” (Benjamin, 1966, p. 19) and required biomedical regulation by the HBIGDA SOC (WPATH, 2011b, p. 1) with its “minimal requirements” to manage sex reassignment. The DSM-III (American Psychiatric Association, 1980) provided the diagnostic criteria to pass through the ‘gate’. This governance by the DSM-III (American Psychiatric Association, 1980), whether intentional or not, provided these “true transsexual[s]” the script to comply to that regulation with the “trapped in a male body” (Benjamin, 1966, p. 19) trope and the depiction of desirable

SRS candidates fitting a textbook version of youth, sex appeal and the notion of passing (Denny, 2004).

It would appear that the biomedical model is, at the very least, providing some structure to the 'problem' by giving SRS candidates the opportunity to ease their suffering (Denny, 2004), which is a laudable act. Here, the biomedical model takes control of personal identity, manipulates it to its own ends and coerces trans* people to comply with rigid gender classifications (Spade, 2011). The resultant effect is the dualistic simplification of the problem through its binary approach to gender classifications, where there are men and women. More recent attempts to recognise the messiness of gender (American Psychiatric Association, 2013; WPATH, 2011a) have failed. While offering alternatives to the issue of GD and the existence of genders outside of male and female, the SOC (WPATH, 2011a) and the American Psychiatric Association (2013) still situate SRS as a binary process. For WPATH (2011a, p. 57), there are "male-to-female" and "female-to-male" patients, whereas the (American Psychiatric Association, 2013, p. 452) talks in terms of "the other gender."

Biomedical dominance further situates the notion of SRS in the realm of the physical, where 'changing' is nothing more than a hormonal (Hembree et al., 2009) and surgical act (Hirschauer, 1992) obtained through a prescriptive psychiatric process. This approach neatly compartmentalises the procedure firstly as a psychological game where your script will open the 'gate' followed by surgical sculpture to complete the picture. While this approach appears to satisfy need (the need for surgery and the need to provide that surgery), the more nuanced psychosocial needs of SRS recipients appear not to be

fulfilled in this manner. While current governance literature (American Psychiatric Association, 2013; WPATH, 2011a) concerning SRS proffers gender nonconformity, variable expressions of gender and individualised care regimes, the biomedical model with its scientific and objective outlook fails to take into account the complexity of personal identities and employs "harm reduction approaches" while tinkering at the edges of the "informed consent model" (WPATH, 2011a, pp. 2,35).

It is therefore not surprising then, that the complexities of gender and the transition process for SRS recipients is generally reduced by researchers to the physical aspects of the journey even today (Schneider et al., 2015), to positivistic approaches to psychosocial issues such as quality of life (Costantino et al., 2013; Gómez-Gil, Zubiaurre-Elorza, Esteva de Antonio, Guillamon, & Salamero, 2014; Karpel et al., 2015) or to surgical technique (Leclère, Casoli, & Weigert, 2015). While the above types of studies are contributing to knowledge production, they *too* neatly explain SRS in terms of mainstream biomedical narratives and its recipients as homogenous, thereby disregarding the contradictions and tensions that exist at the personal level and the multiplicity of realities therein.

7.3 SRS AS A SOCIALLY CONSTRUCTED EMBODIED PRACTICE

Employing components of social constructionist theory with its emphasis on everyday life practices embedded in the social world enabled the researcher to explore the contradictions and tensions of the SRS experience by trans* people who lived those experiences and gave voice to those multiple realities (Guba & Lincoln, 2004). The existence of a singular,

objective truth does not 'fit' with how people experience their worlds and the knowledge we constructed about it. As argued in Chapter 3, the concept of self is a site where variability, difference and flux contribute to the development of personal identity (Crossley, 2000) and comprises the "paramount reality" (Berger & Luckmann, 1966, p. 26). In other words, it is 'messy' and "structured both spatially and temporally" (Berger & Luckmann, 1966, p. 26). Consequently, it is a site that is constantly being modified as performers in the social world interact with society and its structures and institutions. The contradictions and tensions explored throughout this thesis gave voice to the multiplicity of experiences of the participants and allowed their voices to recall various events and memories in their own social context (A. Rogers, 2007). The relationships between not only the researcher and the participants, but also between the participants and their wider social world assisted in the development of the narratives through conversations that explored the nuanced ambiguities of transition from their viewpoints.

However, employing Merleau-Ponty's (2012) concept of embodiment as another component of theory facilitated exploration of the body as it is experienced and participants' memories accounted for "uncertainty, ambiguity, and messiness in everyday life" (Ellingson, 2008, p. 245). The transitioning body, by its very definition, is in a constant state of flux and change. The trans* body as experienced transcends the limitations placed on it by society's dualistic notions of gender. Postmodern perceptions of gender make it clear that gender goes beyond, between and outside the binary framework of male and female, which is the predominant mode of understanding the body. Perceptions of gender in the modern era neatly

stigmatised bodies outside the binary framework. Examples of this stigmatisation are reflected in the work of Berger and Luckmann (1966, p. 168, emphasis in original), where it is explained that:

> The male and female versions of reality are socially recognised…thus, there is a predefined dominance of the male version for the male child and of the female version for the female. The child will *know* the version appertaining to the other sex, to the extent that it has been mediated to him by the significant others of the other sex, but he will not *identify* with this version.

This research established that binary notions that employ language such as *other* do not fit the participants' experiences and are viewed as problematic. They represent another example of the dichotomous simplification portrayed in the literature. Berger and Luckmann (1966, p. 168) reduce not being a boy or a girl to a state of "abnormality" where "the child may make the 'wrong choice'" which both objectifies and subjectifies the notion of gender and hence subjective bodily experiences. The complexities of changing gender may exist within a binary framework for those who experience that reality. Indeed, gender can equally be experienced in a non-binary frame or as totally genderless. In doing so, the multiple categories of gender become the property of subjective trans* realities. The above words assume that to be *real*, a choice of male or female needs to be made, whereas it is argued that trans*ness is an alternative reality where multiple genders are possible, and to be *real* cannot be simplified to male and female. Men with a cervix and/or ovaries and women with a prostate gland do not neatly *fit* predefined categories and therefore cannot, by definition, be conjured up as one or the other. As put by Merleau-Ponty (2005), it is the body that is *with me* that perceives and experiences the world where the

biology of the body cannot be considered static and predetermined (Ellingson, 2008).

7.4 EMPLOYING NARRATIVE

> "Here, I would like to recount a little story so beautiful I fear it may well be true." (Foucault, 1969/1971, p. 225)

Narrative reconstruction of life events as a mode of knowledge production had its beginnings in antiquity (Lyons, 2007; Riessman, 2008). With its beginnings in the world of Greek tragedy and farce (Riessman, 2008), narrative has shaped and reshaped history. As explained by Lyons (2007, p. 602), "[t]he power of narrative is as old as human history." The power is recognised through "stories lived and told" (Clandinin & Connelly, 2000). Narratives are a way in which sense is made of life events through reflecting upon past events in present circumstances to find ways to project that event into the future. That is to say, sense is made in a way that is "relational and directional" (Kellett, 1997, p. 63). The act of storytelling provides a greater understanding of both ourselves as individuals and the world around us (Wittgenstein, 1953/1967).

Employing narrative in this study essentially empowered the participants to recount deeply emotional personal experiences that were "culturally meaningful and recognizable" (Mishler, 1995, p. 91) to them in a way that accounted for the durability of their narratives (Ricoeur, 1981b) and their changing narrative identities over time. This durability is dependent upon social, cultural and political circumstances (Willis & Elmer, 2011), the

importance of specific stories in a particular context and how those stories are understood by and converge/diverge with stories by others (Collie & Long, 2005). Narrative accounted for the variability and flux of individual story lines (Crossley, 2000) and the understanding was shared in conversation with the researcher who brought her own "stories lived and told" (Clandinin & Connelly, 2000) to the research. Narratives, bodies, identities and lives are never constructed in a vacuum, but in a social context. It is about thoughts, ideas, and emotions embedded in a dynamic social relationship where the nuances of the plot are co-constructed.

Reflecting upon the words of Foucault (1969/1971) above, the concept of 'true' in storytelling relies upon the temporal aspects of the narrative. Identities develop and narratives are "undertaken through time" (Clandinin & Rosiek, 2007, p. 40), where the 'kairos', that moment in time when it is the appropriate time to say or do the appropriate thing (Ricoeur, 1981b) is not a limiting factor of the narrative. The beauty of narratives is that they are constructed, adapted and modified constantly in search for meaning, and herein lies what it is to be 'true'. As M. White and Epston (1990, p. 11) explain:

> The structuring of a narrative requires recourse to a selective process in which we prune, from our experience, those events that do not fit with the dominant evolving stories that we and others have about us. Thus, over time, and of necessity, much of our stock of lived experience goes unstoried and is never "told" or expressed.

As suggested by M. White and Epston (1990, p. 11), "dominant evolving stories" are an essential component of our socially constructed lives and encapsulates Ricoeur's (1991b) notion of narrative durability that interrogates

past, present and future. From my epistemological perspective, the timing of the narrative celebrates the nuances of our existence, as it provides the impetus for growth, meaning and understanding. These nuances are reflected in the participants' narratives which arise from the experience of self. It is argued, then, that the narrative is more than merely a personal account; it is about human experience and it honours the participants' voices. Narrative "begins with an ontology of experience…[it is] relational, temporal, and continuous, it arrives at a conception of how that reality can be known" (Clandinin & Rosiek, 2007, p. 44).

7.5 MAKING SENSE OF SRS

The focus of this study was to explore the perceptions of trans* people who had undergone SRS and their psychosocial experiences, and how they navigated surgical transition. The analysis deliberately steered away from the traditional methods of finding consistent themes in the data. Instead, the narrative concepts developed from the data looked not at the sameness among the narratives, but differences, contradictions and variations on the overall concept of self. The concept of self originated from viewing how the participants' trans* identities developed from a whole of life perspective which was grounded in the data and the philosophical stance of the researcher.

Knowledge and reality were negotiated through interaction with the social world which recognised that society is as complex and diverse as its constituent parts. This research employed language (verbal, written, visual and embodied) as the medium to gain a deeper understanding of the participants experiences; an approach based on the assumption of multiple

realities. The multiplicity of reality is reflected in the homogenous and heterogeneous experiences of the participants. Trans* men and trans* women are the same but they are also different. Their accounts of transition conveyed how life as a trans* person pursuing SRS is made remarkable by the world around them.

Society's institutions controlled access to SRS. The western biomedical model of health ensured that SRS came at a cost; a psychiatric diagnosis of GD that impacted upon everyday lived experience through its gatekeeping practices and the need to follow a neat, prescriptive checklist to gain access to surgery. A diagnosis of GD repathologised being a trans* person in everyday life. Convoluted legal systems with rigid legislative requirements controlled the way in which trans* people became legitimate in the eyes of society in ways that discriminated against some participants and delegitimised their identities. The traditional family and its values attempted to impose constraints on some participants related to symbolic rituals and religious beliefs, while coming to terms with transition left some participants and family members socially excluded. As a result of the structural and interpersonal stigma (White Hughto, Reisner, & Pachankis, 2015) imposed upon trans* people, the individual beliefs and behaviours of some trans* people internalised the stigma. However, their narratives also speak of personal satisfaction to stand up for and stand out as themselves despite those constraints placed upon them by society and its institutions. In effect, their stories tell a tale of resilience through adversity, and SRS provided that resilience by allowing them to reclaim what they perceived was their innermost identity.

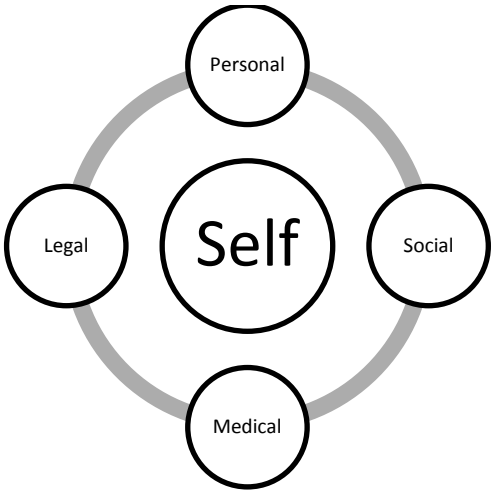


Figure 11. The four concepts of self

The four concepts of self displayed in *Figure 11* represent the ways that this research allowed the self to have a voice, and the analysis was grounded in those concepts. Each aspect of self is not distinct in itself, but they were derived from the data to focus the analysis. The intersection of the personal, social, medical and legal selves signifies the complex everyday existence of trans* people pursuing SRS as they attempt to lead a life that strives to be unremarkable, but is socially constructed as remarkable.

7.6 FUTURE POSSIBILITIES

> …the future is necessarily monstrous: the figure of the future, that is, that which can only be surprising, that for which we are not prepared, is heralded by species of monsters. A future that would not be monstrous would not be a future; it would already be a predictable, calculable, programmable tomorrow. (Derrida, 1995, pp. 386-387)

The words of Derrida (1995) above reiterate the notion that trans* people occupy a space outside of social acceptability and that Australia, in terms of scholarship, is largely unprepared for the rapid escalation of trans*

and gender diverse people in Australia if we consider the estimated prevalence of 1.4% of the world population by the Equality and Human Rights Commission (2012) an accurate assessment. This research has clearly demonstrated that there are levels of inconsistency at the systems level (medical and legal) when it concerns dealing with trans* people, not only those pursuing SRS, but more broadly among the gender non-conforming population. The provision of appropriate health care services by knowledgeable, respectful healthcare professionals is a necessary outcome. Additionally, there is a knowledge deficit throughout the medical and education sectors.

Participants in the current study highlighted the varying attitudes and levels of knowledge by medical professionals when treating trans* people in the health care system. As evidenced by the greater public awareness of trans* related issues in the media in recent times, the emergence of trans* children being treated for gender dysphoria as young as three (Hewitt et al., 2012) in Australia and the call by the Australian Medical Students Association (2014) and the Australian Human Rights Commission (2015) to become more knowledgeable in such issues, it is manifestly apparent that more health professionals will need to expand their knowledge base. Doctors and nurses are key links in the transition chain and can directly affect the way in which healthcare is delivered towards trans* people. Therefore, the education of doctors, nurses and other healthcare workers is of critical importance. That is not to say that Bachelor of Medicine and Bachelor of Nursing degrees undergo sweeping changes to their curricula to accommodate such issues. However, the complexities of trans* gender

identities, the psychosocial issues they face, appropriate communication strategies and the like, I would suggest, can be easily superimposed into existing educational structures to begin the awareness process. Additionally, at the clinical level, comprehensive in-service training should be made available in acute care for existing medical professionals.

This research has also highlighted the significance of forming better relationships between trans* people and healthcare providers, not in isolation of each other, but by forming mutually cooperative partnerships. Although SRS is a goal in life for those trans* people following that trajectory, it is not the end of the story. Life goes on beyond that 'final cut' and should not be seen in isolation to ongoing needs throughout the lifespan. Science and medicine do not hold all the answers, but this research suggests the power of medical systems overrides personal narratives. I am reminded of the words of Canguilhem (1989, pp. 92-93, emphasis in original), who stated:

> The disease which never existed in the man's consciousness begins to exist in the physician's science. We think *that there is nothing in science that has not first appeared in the consciousness,* and that in the case before us, it is particularly the sick man's point of view which forms the basis of truth.

It is not just the science of medicine that plays a role in the surgical performance, but the standards that guide that performance. The SOC [Version 7] (WPATH, 2011a) are the internationally recognised guidelines concerned with the care of trans* people. An interpretation of those guidelines reflects the view that while there are substantial benefits in the guidelines in many areas with extensive detail supplied on such topics as hormone therapy and health professional protocols, there is a lack of detail in

other areas, such as communication and psychosocial issues. From this analysis, I suggest that a new section on communication with trans* people be included as this research has highlighted the importance of communication in the health and wellbeing of trans* people. Additionally, I suggest that the guidelines could be enhanced by providing greater detail on the psychosocial issues experienced by trans* people, thereby giving greater guidance to those health professionals who have limited or no knowledge of trans* related issues.

At a legal level, the plethora of legislation and court rulings currently in operation in Australia is an unworkable situation and contributes to the psychosocial burden of trans* people in Australia. Anecdotally, it has been suggested that the Commonwealth government should construct overarching legislation for trans* people. This study suggests that this approach would merely add another layer to the confusion and inconsistencies already existing based upon our Federal system of government. I am suggesting a way forward whereby there is consistency at Federal, State and Territory levels of government, which will decolonise, if you will, the legislative Pandora's Box.

The Sex Files Project (Australian Human Rights Commission, 2009) was a good start towards recognition of sex and gender diversity. However, it did not come from a whole of government perspective. The majority of the State and Territory governments were not involved. Feedback was only sought from within certain areas of the Commonwealth Government and only three States were involved. More recently, the Australian Human Rights Commission (2015) released a report conducted through a consultative

process with LGBTI people on issues of discrimination and human rights concerns, which further echo the findings of my study including amending anti-discrimination laws, and removing the requirement of getting a divorce to change gender markers.

However, the report falls short of recommending amendment to the various State and Territory legislation surrounding changing gender markers, although it recognises it is an area of concern. Therefore, I strongly recommend a consolidated approach involving the Council of Australian Governments (COAG), the Council of Australian Registrars (COAR), the Australian Human Rights Commission and of course, trans* people as the key stakeholders to arrive at a consensus on appropriate trans* friendly legislation where it comes to changing gender markers in particular. This study highlighted inherent problems of multiple legislations and the crisis especially for trans* men, who do not all choose to undergo 'bottom' surgery for medical, logistical and financial reasons. The birth certificate is, after all, *the* cardinal document that defines our existence and our identity. The health and wellbeing of trans* people is bound in the social fabric of the nation. The myriad of laws enacted by 10 governments around Australia contribute to the mental health issues faced by trans* people as they impede what cisgender people take-for-granted: an unremarkable everyday life.

Finally, further qualitative research around issues concerning trans* people is needed. There remains a paucity of research in Australia on trans* related health issues, although it is notable that some vital work has recently been completed in the areas of mental health (Hyde et al., 2014; E. Smith et al., 2014), life as a young trans* person (E. Smith et al., 2014), the

experiences of trans* men (T. Jones et al., 2015) and access to healthcare services (Riggs & Due, 2013). Areas of concern within the adult population include HIV among trans* women sex workers, provision of aged care services in consideration of the rapidly ageing population in Australia, and attitudes of health professionals towards trans* people, for example. There are also an increasing number of children presenting at earlier ages (Hewitt et al., 2012). Possible avenues of research include navigating educational systems as trans* identified children, the social and legal challenges of obtaining puberty blockers and hormone therapy during the teen years in Australia, and the perception of experiences surrounding peer and parental acceptance as a trans* identified child.

7.7 A PERSONAL REFLECTION ON COMPLEXITY

The finality of the surgical transition and how trans* people navigated that process from a whole of life perspective demonstrated the complexity of the trans* phenomenon. This complexity compelled me to reflect upon my own complexities and realities as I come to terms with my own existence as a trans* woman whose journey began well over 50 years ago. I previously hinted that the classical trans* story of being in the 'wrong body' fitted my view of the world, much like some of the participants in this study. During the course of this study, that view of my reality has shifted into the 21st century. I now describe that as my transnormativity. My transnormativity is a way to define my trans* experience. It is individualised and defines my gender as it fits my box and no one else's. The earliest recollections of my trans*ness are embedded in very early childhood memories (late 1950s/early 1960s) of play

with my sister Denise, who has a very profound intellectual disability and was labelled a ‘mental retard’ and a ‘spastic’ by society (another form of the ‘monster’). In many ways I was socialised as a ‘girl’ in the family in the guise of looking after my sister. I learned to knit and sew. It wasn’t uncommon for me to be dressing Barbie (the doll) up, knitting and sewing outfits for her, knitting scarves and the like for me to wear. I learned to cook and baking on Sundays with my maternal grandmother was an activity I enjoyed, and I could pretend to be mother. Those ‘girl’ things became a part of my life.

In the 50s and 60s, such deviant behaviour existed outside the social norm, but it seemed natural and normal to me. I could express myself in this way and be happy with that. At primary school, I played skip rope with the girls at lunchtime, but this is when my behaviour became problematic among wider social networks. It was 1962 when I was called into the headmaster’s office for the reason that I was an 8 year old boy in Grade 3 regularly playing skip rope with the girls. This imposing, very tall, and somewhat grandfatherly gentleman man stood me there, pointed his finger at me, and said with a sternness that encapsulated the stereotypical headmaster of the era, “If you don’t stop playing with the girls, I’m going to put you in a dress.” That brought a big smile to my face, and not the reaction intended. It was at that point I knew I wasn’t like all the other boys. I fantasised about wearing that dress – it was something that I did whenever the opportunity arose. Although socially at school, I knew I needed to change my behaviour and so I did all the boy things as expected. By Grade 6, I was House Captain, played cricket and football but in private, I was the opportunistic girl.

There was this one dress grandma owned that she crocheted in the 1920s and it lived in my bedroom at her house. Every weekend, I visited grandma. I'd lock myself in the bedroom and parade around in that dress. There was another dress, a brightly coloured summer dress my cousin June owned. June and Aunty Hazel came to live at our house when she divorced Uncle Norm. I snuck into June's room a couple of times and that's when my secret came out because I got caught in the act. Doing girl things which had been encouraged previously as playing with my sister were now taboo. My clandestine dressing up in real girl's clothes was substituted by adapting my own clothes in creative ways, such as putting a jumper on my head to resemble long hair in the privacy of my bedroom. But my fantasies of being the girl I thought I was continued in other ways as well. I would tuck my penis between my legs so that it didn't exist anymore and I would wonder why I wasn't a real girl. I learned to cleverly disguise my behaviour to avoid punishment and humiliation. I was a private girl.

At puberty, things changed and I became confused as normal male sexual things began anatomically and I followed that road. I had a very small circle of male friends now and being with the girls seemed abhorrent to me. Was this the girl in me being attracted to the boys? In some ways, I think it may have been. But at that time, I buried the girl in me because my teenage body told a different narrative. I navigated those teenage years by concentrating upon my education. It was the only avenue I could reasonably pursue that didn't involve my twisted and confusing identity. In many ways, it was easy to alienate myself as a form of self-protection, much like Holden Caulfield in J. D. Salinger's (1958) "*The Catcher in the Rye*." It wasn't until I

finished high school and left home that I began to experiment in ways that were socially acceptable. Kaftans and long hair were the rage as the hippie movement, with its folk songs about peace and war, coffee shops and illicit drugs engulfed the psyche of the younger generation. I could fit quite easily into that mould and get away with being a semi-girl.

One afternoon, I was walking down Sydney Road, Coburg, in Victoria. By this time, I was mixing and matching boys and girls clothes and my hair was quite long. I had a Miller's Shirt, popular at the time, and I tied it in front to create a different look with it. While I'm walking down the street, I heard these two girls around my age chatting and one said "Look at what that girl has got on." That also brought a smile to my face. Perhaps I could be a real girl.

It was at this time, I began to present socially more often, but I was still unsure of any direction to take. It was getting serious now, and I needed to make some decisions about my life. I was quite lost, alone in the world and quite transient, turning up at different peoples' flats and so on, as I searched for answers. I ended up staying at a flat with these two gay guys in their spare room with my meagre set of belongings and photographic memories of my life thus far, but was still quite transient in nature. I suppose I had been there a few months, but only stayed there in an ad hoc fashion. I still had no idea of what direction I should take. Now, I've never been a religious person, but being at this junction in my life, I needed to make a decision and I asked for some type of spiritual guidance. I needed a sign. I literally looked at the heavens and asked for help. "Should I be a boy or a girl?"

I returned to where I had been staying with those two gay guys and knocked on the door as my key did not work. A young guy opened the door that I didn't know. We had a brief conversation; the punch line being, those two gay guys had moved out and had taken all my belongings with them. I now had nothing except for the clothes on my back. That was the sign. My previous life and all the memories I had of it were a thing of the past and the only way forward was to be the girl I'd always knew myself to be. I was the new girl on the block.

This excursion into my personal narrative is grounded in the methodology of narrative inquiry, where "as inquirers we meet ourselves in the past, present, and the future", as Clandinin and Connelly (2000, p. 60) state. For Fay (1996), past, present and future are fluid entities as we remember the past from our present viewpoint. This aspect is reflected in how I perceive my gender today. My association with "*the born in the wrong body"* trope (A. Johnson, 2015, p. 807, emphasis in original), the grand trans* narrative of the 20th century, now occupies a space as my transnormative existence; effectively what Neisser (1994, p. 2, emphasis in original) refers to as "the *remembered self* constructed on that occasion." Memories of my childhood and adolescence were stirred up as I pondered the analysis of the lives of the participants in this study and how our common narratives, linked by being trans* people and our need for SRS, shaped and reshaped our futures. But at the same time, our narratives were distinctly unique. However, from my perspective as a narrative inquirer, research into the social world of trans* people can never be called a neutral activity for the reason that our some of our knowledges are shared knowledges and the co-

construction of knowledge is assumed. Neutrality would place this research in the realm of the scientific and its knowledge would be *"bounded"*[87] (Pinnegar & Daynes, 2007, p. 10, emphasis in original). The social relationships between me and the participants in this study and the knowledge we created together with pictures and conversations, in narrative terms, is what Craig and Huber (2007, p. 272) refer to as "relational forms of knowing." In this respect, although the research is theoretically informed, it "maintain[s] fidelity to [the] research participants" (Craig & Huber, 2007, p. 272) and honours the stories told of their lived experiences by reflecting their thoughts and emotions. However, in this field of research, as Clandinin and Connelly (2000, p. 62) suggest, sharing a space with participants requires a certain visibility. In their words:

> This confronting of ourselves in our narrative past makes us vulnerable as inquirers because it makes secret stories public. In narrative inquiry, it is impossible (or if not impossible then deliberately self-deceptive) as researcher to stay silent or to present a perfect, idealized, inquiring, moralizing self.

To this end, it emphasises my relationship as occupying a space between the dichotomies of insider-outsider; a space where sameness and difference become fused (Fay, 1996), knowing is blurred (Pinnegar & Daynes, 2007) and interaction is "rich and messy" (Bruner, 1991, p. 4). As (Fay, 1996, p. 241) argues, "[f]requently an entity can be in both categories; or one category gradually slides over into its supposed opposite; or binary alternatives rest on fallacious presuppositions which mistakenly restrict the range of possible choices."

[87] Pinnegar and Daynes (2007, p. 10), explain bounded as "the knowledge of the researcher and the knowledge of the researched [as] separate and distinct from each other."

7.8 A FINAL COMMENTARY: SRS DECONSTRUCTED

> …yet such is my unseemliness: I hate my epidermal dress, the savage blood's obscenity, the rags of my anatomy, and willingly would I dispense with false accoutrements of sense, to sleep immodestly, a most incarnadine and carnal ghost. (Roethke, 1941)

American poet Theodore Roethke (1908-1963) in his acclaimed poem *"Epidermal Macabre"* (1941) could be interpreted as applicable to the perceptions and experiences of those undergoing SRS. It reflects participants' descriptions with its elements of grotesqueness of their natal form reclaiming their identity through SRS. These fleshy 'rags' were so despised and impeded reclamation; ultimately controlled by the whims of social institutions. That 'carnal ghost' in the form of socially constructed medical and legal complications that coerce trans* people to live this life as biological, social and legal abnormalities – recall the monster (Foucault, 2003). The trans* 'monster' of the 21st century has the 'decidability'[88] to transfigure themselves but remain unsure of the eventual outcome while locating, filtering and deciphering the resources that may or may not exist to facilitate that transition. Indeed, we are socialised to expect that the biomedical discourse will fix our broken parts (Willis & Elmer, 2011). It would appear that little has changed since 1779 when a surgeon, Mr Thomas Brand, as reported by Warren (2014, p. 872), "surgically reassigned the gender of a seven-year-old child from female to male, thus enabling him to urinate standing up, wear trousers, and enjoy the privileges of being a male." Nonetheless, reclaiming personal identity is an emotional rollercoaster that

[88] This aspect refers to a personal decidability to make a physical change through SRS. It is an antithesis to the "undecidability" that Foucault (2003, p. 65) speaks of as a social and legal Pandora's Box.

heteronormative people on the periphery fail to understand for the reason that this ‘medical condition’ wrongly implies sickness and disease and is played out as a “sculptural practice” by surgeons (Hirschauer, 1998, p. 21). This “bloody ritual” (Hirschauer, 1992, p. 131) culturally blurs the gender divide of male and female in ways that society has yet to come to terms with.

For some participants, the odour of that non-healing wound builds up and lingers over decades. For other participants, it is merely an acute ‘blip on the radar’. I reiterate; SRS can never be a linear process, although Vitale (2010, p. 99) argues that it is a linear process for most. Not all can or do take that ‘yellow brick road’ to gender euphoria, finally reaching that euphoric space where the corporeal world once again becomes embodied and aligned with the psychological world. Those complexities and multiple realities of trans* life, if you will, are neatly encapsulated by what Prosser (2005, p. 116) refers to as the “desultoriness of experience.” The random nature of existence; encountering adversity and finding resilience through every action is a common thread throughout this research. The lives of the trans* men and women in this study exemplify and live those multiple realities. SRS provided the starting point to embark upon a reclaimed existence; it was the ‘final cut’ but it wasn’t the ‘final word’, as the following participant produced drawing, entitled *“Emergence”* depicts:

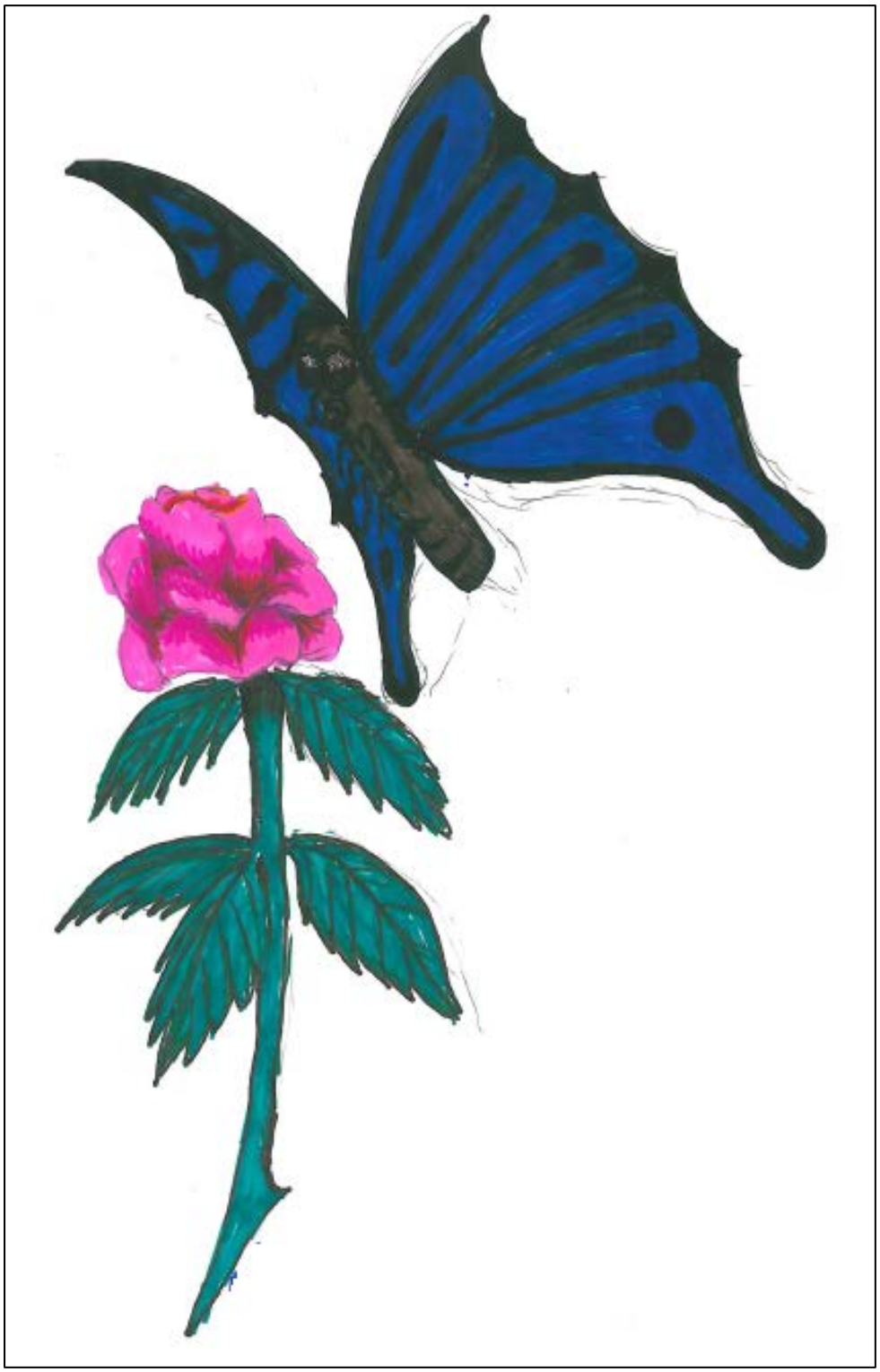


Figure 12. "I hadn't blossomed and it feels like I was that caterpillar. I was stuck down at ground level and couldn't really spread my wings and be my true self in all my glory. [Transitioning] allowed me to actually bloom and be 100% my true self and not be afraid of being that." (Ms Mel, female, age 50)

The sky's the limit…

References

AB v. State of Western Australia & Anor, No. P15/2011 42 HCA (2011).

Abraham, F. (1931/1997). Genital reassignment on two male transvestites. *International Journal of Transgenderism, 2*(1). Retrieved from http://www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtc0302.htm

Adams, C., & van Manen, M. (2008). Phenomenology. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 2, pp. 614-619). Los Angeles: SAGE.

Aguinaldo, J. (2004). Rethinking validity in qualitative research from a social constructionist perspective: From "is this valid research"? to "what is this research valid for"? *The Qualitative Report, 9*(1), 127-136. Retrieved from http://www.nova.edu/ssss/QR/QR9-1/aguinaldo.pdf

AH v. State of Western Australia & Anor, No. P16/2011 42 HCA (2011).

Allsop, J. (2006). Medical dominance in a changing world: The UK case. *Health Sociology Review, 15*(5), 444-457. doi: 10.5172/hesr.2006.15.5.444

Altheide, D., & Johnson, J. (2011). Reflections on interpretive adequacy in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The SAGE book of qualitative reserarch* (pp. 581-594). California: SAGE Publications.

Alvesson, M., & Sköldberg, K. (2009). *Reflexive methodology: New vistas for qualitative research* (2nd ed.). London: SAGE Publications Ltd.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders: DSM-III. Retrieved February 22, 2010, from http://www.psychiatryonline.com.ezp01.library.qut.edu.au/DSMPDF/dsm-iii.pdf

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders: DSM-III-R*. Washington, D.C.: American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington: American Psychiatric Association.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders: DSM-IV-TR. Retrieved October 22, 2012, from http://dsm.psychiatryonline.org/book.aspx?bookid=22

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders DSM-5.* Washington DC: American Psychiatric Publishing.

American Psychological Association. (2011). About transgender people, gender identity, and gender expression. Retrieved November 20, 2014, from http://www.apa.org/topics/lgbt/transgender.pdf

Andrews, M., Squire, C., & Tamboukou, M. (Eds.). (2008). *Doing narrative research*. Los Angeles: Sage Publications.

Ansara, Y., & Hegarty, P. (2013). Misgendering in English language contexts: Applying non-cisgenderist methods to feminist research. *International Journal of Multiple Research Approaches, 7*(2), 160-177. doi: 10.5172/mra.2013.7.2.160

Ansara, Y., & Hegarty, P. (2014). Methodologies of misgendering: Recommendations for reducing cisgenderism in psychological research. *Feminism & Psychology, 24*(2), 259-270. doi: 10.1177/0959353514526217

Anti-Discrimination Act. (1977) (NSW). Austl.

Anti-Discrimination Act. (1991) (Qld). Austl.

Anti-Discrimination Act. (1998) (Tas). Austl.

Anti-Discrimination Act. (2011) (NT). Austl.

Archive for Sexology. (n.d.). Harry Benjamin (1885-1996). Retrieved December 19, 2012, from http://www2.hu-berlin.de/sexology/GESUND/ARCHIV/COLLBEN.HTM

Australian Bureau of Statistics. (2007). National survey of mental health and wellbeing. Retrieved June 4th, 2012, from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4326.02007?OpenDocument

Australian Bureau of Statistics. (2012). Population clock. Retrieved November 12, 2012, from http://www.abs.gov.au/ausstats/abs%40.nsf/94713ad445ff1425ca25682000192af2/1647509ef7e25faaca2568a900154b63?OpenDocument

Australian Government. (2013). Australian Government guidelines on the recognition of sex and gender. Retrieved September 30, 2013, from http://www.ag.gov.au/Publications/Documents/AustralianGovernmentGuidelinesontheRecognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.PDF

Australian Human Rights Commission. (2009). Sex files: The legal recognition of sex in documents and government records. Retrieved June 12, 2013, from http://www.humanrights.gov.au/sites/default/files/content/genderdiversity/SFR_2009_Web.pdf

Australian Human Rights Commission. (2015). Resilient individuals: Sexual orientation, gender identity & intersex rights. Retrieved July 1, 2015, from http://www.humanrights.gov.au/our-work/sexual-orientation-sex-gender-identity/projects/sogii-rights

Australian Medical Students Association. (2014). Lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) health policy. Retrieved March 31, 2014, from http://media.amsa.org.au/policy/2014/201403_LGBTIQ_Health_Policy.pdf

Bach, H. (2007). Composing a visual narrative inquiry. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 280-307). California: Sage Publications, Inc.

Baddeley, J., & Singer, J. (2007). Charting the life story's path. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 177-202). California: SAGE.

Barling, J. (2005). Assessment and diagnosis. In R. Elder, K. Evans & D. Nizette (Eds.), *Psychiatric and mental health nursing* (pp. 147-172). Sydney: Elsevier.

BBC News Liverpool. (2012, December 13). April Ashley: MBE for transgender campaigner. Retrieved May 21, 2014, from http://www.bbc.com/news/uk-england-merseyside-20708017

Beemer, B. (1996). Gender dysphoria update. *Journal of Psychosocial Nursing & Mental Health Services, 34*(4), 12-19. Retrieved from http://www.healio.com/journals/jpn

Bending, Z. (2015). Reconceptualising the doctor–patient relationship: Recognising the role of trust in contemporary health care. *Journal of Bioethical Inquiry, 12*(2), 189-202. doi: 10.1007/s11673-014-9570-z

Benjamin, H. (1966). *The transsexual phenomenon.* New York: The Julian Press.

Bennett, T. (2013). Transsexualism and the consideration of social factors within sex identification law. *Adelaide Law Review, 34*(2), 379-402. Retrieved from http://www.adelaide.edu.au

Bentley, K. (2010). Psychiatric medication and meaning-making in a residential program for adults with serious mental illness. *Qualitative Social Work, 9*(4), 479-499. doi: 10.1177/1473325010367822

Berger, P., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Anchor Books.

Bergum, V., & Godkin, D. (2008). Nursing research and the transformative value of art. In J. G. Knowles & A. L. Cole (Eds.), *Handbook of the arts in qualitative research : Perspectives, methodologies, examples, and issues* (pp. 603-612). Los Angeles: Sage Publications.

Beyondblue. (n.d.). Stats and facts. Retrieved March 4, 2016, from https://www.youthbeyondblue.com/footer/stats-and-facts

Billings, D., & Urban, T. (1982). The socio-medical construction of transsexualism: An interpretation and critique. *Social Problems, 29*(3), 266-282. doi: 10.2307/800159

Bird, S. (2002). Re Kevin (validity of marriage of transsexual) [2001] FamCA 1074. *Southern Cross University Law Review, 6*, 364-371. Retrieved from http://heinonline.org

Births Deaths and Marriages Registration Act. (1995) (NSW): Austl.

Births Deaths and Marriages Registration Act. (1996) (Vic). Austl.

Births Deaths and Marriages Registration Act. (1997) (ACT). Austl.

Births Deaths and Marriages Registration Act. (1999) (Tas). Austl.

Births Deaths and Marriages Registration Act. (2003) (Qld). Austl.

Births Deaths and Marriages Registration Amendment Act. (2014) (ACT). Austl.

Blumer, H. (1969). What is wrong with social theory? *Symbolic interactionism perspective and method* (pp. 140-152). New Jersey: Prentice-Hall, Inc.

Blumer, H. (1979). *Critiques of research in the social sciences: An appraisal of Thomas and Znaniecki's The Polish peas*. New Jersey: Transaction Books.

Blyton, E. (1978). *Famous five TV special*. Kent: Hodder and Stroughton.

Bockting, W. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211-224. doi: 10.1016/j.sexol.2008.08.001

Bockting, W., Knudson, G., & Goldberg, J. (2006). Counseling and mental health care for transgender adults and loved ones. *International*

Journal of Transgenderism, 9(3-4), 35-82. doi: 10.1300/J485v09n03_03

Bower, H. (2001). The gender identity disorder in the DSM-IV classification: A critical evaluation. *Australian & New Zealand Journal of Psychiatry, 35*(1), 1-8. doi: 10.1046/j.1440-1614.2001.00859.x

Bowman, C., & Goldberg, J. (2006). Care of the patient undergoing sex reassignment surgery. *International Journal of Transgenderism, 9*(3-4), 135-165. doi: 10.1300/J485v09n03_07

Boyle, F., Dunne, M., Najman, J., Western, J., Turrell, G., Wood, C., & Glennon, S. (1997). Psychological distress among female sex workers. *Australian and New Zealand Journal of Public Health, 21*(6), 643-646. doi: 10.1111/j.1467-842X.1997.tb01770.x

Boza, C., & Nicholson Perry, K. (2014). Gender-related victimization, perceived social support, and predictors of depression among transgender Australians. *International Journal of Transgenderism, 15*(1), 35-52. doi: 10.1080/15532739.2014.890558

Breen, L. (2007). The researcher "in the middle": Negotiating the insider/outsider dichotomy. *Australian Community Psychologist, 19*(1), 163-174. Retrieved from https://groups.psychology.org.au

Brown, G. (2009). Recommended revisions to the World Professional Association for Transgender Health's Standards of Care section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 11*(2), 133-139. doi: 10.1080/15532730903008073

Brown, G. (2010). Autocastration and autopenectomy as surgical self-treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 12*(1), 31-39. doi: 10.1080/15532731003688970

Brown, J., Karley, M., Boudville, N., Bullas, R., Garg, A., & Muirhead, N. (2008). The experience of living kidney donors. *Health & Social Work, 33*(2), 93-100.

Browne, K. (2005). Snowball sampling: Using social networks to research non-heterosexual women. *International Journal of Social Research Methodology, 8*(1), 47-60. doi: 10.1080/1364557032000081663

Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry, 18*(1), 1-21. Retrieved from http://www.jstor.org/stable/1343711

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge, Chapman and Hall, Inc.

Canguilhem, G. (1989). *The normal and the pathological* (C. Fawcett, Trans.). New York: Zone Books.

Canguilhem, G. (2000). *A vital rationalist* (A. Goldhammer, Trans.). New York: Zone Books.

Canguilhem, G., & Jaeger, T. (1962). Monstrosity and the monstrous. *Diogenes, 10*(40), 27-42. doi: 10.1177/039219216201004002

Carlotta. (2012). Carlotta. Retrieved September 23, 2013, from http://www.carlotta.com.au/Carlotta/Home.html

Castellano, E., Crespi, C., WDell'Aquila, Rosato, R., Catalano, C., Mineccia, V., . . . Manieri, C. (2015). Quality of life and hormones after sex

reassignment surgery. *Journal of Endocrinological Investigation, 38*(12), 1373-1381. doi: DOI 10.1007/s40618-015-0398-0

Cauldwell, D. (1949). Psychopathia transsexualis. *Sexology, 16*, 274-280.

Cauldwell, D. (1951/2001). Sex transmutation - Can one's sex be changed? There's but a thin line between the sexes, but the would-be transmutee battles forces more stubborn than the genes. *International Journal of Transgenderism, 5*(2), 1-29. Retrieved from http://www.iiav.nl

Chamberlin, T., & Brennan, R. (2014, October 7). Monster chef and the she male [Newspaper article], *The Courier Mail,* pp. 1, 4-5.

Chaplin, B. (2011). *Sex reassignment surgery: Panacea, placebo or Pandora's box? - A narrative inquiry (Unpublished honours dissertation)*. Queensland University of Technology, Brisbane, Queensland.

Chaplin, B. (2012). *Multiple realities* [Photographic Collage]. Brisbane, Qld.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE.

Childs, M. (2009). Transsexualism: Some theological and ethical perspectives. *Dialog: A Journal of Theology, 48*(1), 30-41. doi: 10.1111/j.1540-6385.2009.00428.x

Chung, W., de Vries, G., & Swaab, D. (2002). Sexual differentiation of the bed nucleus of the stria terminalis in humans may extend into adulthood. *The Journal of Neuroscience, 22*(3), 1027-1033. Retrieved from http://www.jneurosci.org

Clandinin, D., & Connelly, M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.

Clandinin, D., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. Clandinin (Ed.), *Hndbook of narrative inquiry: Mapping a methodology* (pp. 35-75). California: Sage Publications, Inc.

CNSNEWS. (2015, June 2). John Hopkins psychiatrist: Transgender is 'mental disorder;' Sex change 'biologically impossible'. Retrieved June 2, 2015, from http://cnsnews.com/news/article/michael-w-chapman/johns-hopkins-psychiatrist-transgender-mental-disorder-sex-change

Cohen-Kettenis, P., & Gooren, L. (1999). Transsexualism: A review of etiology, diagnosis and treatment. *Journal of Psychosomatic Research, 46*(4), 315-333. doi: 10.1016/S0022-3999(98)00085-3

Cohen-Kettenis, P., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior*. doi: 10.1007/s10508-009-9562-y

Cohen, D., & Crabtree, B. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *The Annals of Family Medicine, 6*(4), 331-339. doi: 10.1370/afm.818

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165-232. doi: 10.1080/15532739.2011.700873

Collie, K., & Long, B. (2005). Considering 'meaning' in the context of breast cancer. *Journal of Health Psychology, 10*(6), 843-853. doi: 10.1177/1359105305057318

Collyer, F., & Heal, C. (2002). Patient satisfaction with sex re-assignment surgery in New South Wales, Australia. *Australian Journal of Primary Health, 8*(3), 9-19. Retrieved from http://www.publish.csiro.au

Commonwealth of Australia Constitution Act. (2003) (Clth). Austl.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic Masculinity: Rethinking the Concept. *Gender & Society, 19*(6), 829-859. doi: 10.1177/0891243205278639

Costantino, A., Cerpolini, S., Alvisi, S., Morselli, P., Venturoli, S., & Meriggiola, M. (2013). A prospective study on sexual function and mood in female-to-male transsexuals during testosterone administration and after sex reassignment surgery. *Journal of Sex & Marital Therapy, 39*(4), 321-335. doi: 10.1080/0092623X.2012.736920

Couch, M., Pitts, M., Croy, S., Mulcare, H., & Mitchell, A. (2008). Transgender people and the amendment of formal documentation: Matters of recognition and citizenship. *Health Sociology Review, 17*(3), 280-289. doi: 10.5172/hesr.451.17.3.280

Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A., & Patel, S. (2007). Tranznation: A report on the health and wellbeing of transgender people in Australia and New Zealand. Retrieved December 14, 2009, from http://glhv.org.au/files/Tranznation_Report.pdf

Cowles, K., & Rodgers, B. (1991). The concept of grief: A foundation for nursing research and practice. *Research in Nursing & Health, 14*(2), 119-127. doi: 10.1002/nur.4770140206

Crabtree, B., & Miller, W. (1999). Using codes and manuals: A template organizing style of interpretation. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (2nd ed., pp. 163-177). California: Sage Publications, Inc.

Craig, C., & Huber, J. (2007). Relational reverberations: Shaping and reshaping narrative inquiries in the midst of storied lives and contexts. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 251-279). California: Sage Publications, Inc.

Croghan, C., Moone, R., & Olson, A. (2014). Friends, family, and caregiving among midlife and older lesbian, gay, bisexual, and transgender adults. *Journal of Homosexuality, 61*(1), 79-102. doi: 10.1080/00918369.2013.835238

Crossley, M. (2000). Narrative psychology, trauma and the study of self/identity. *Theory & Psychology, 10*(4), 527-546. doi: 10.1177/0959354300104005

Curtis, S., Gesler, W., Smith, G., & Washburn, S. (2000). Approaches to sampling and case selection in qualitative research: Examples in the geography of health. *Social Science & Medicine, 50*(7-8), 1001-1014. doi: 10.1016/S0277-9536(99)00350-0

Damodaran, S., & Kennedy, T. (2000). The Monash Gender Dysphoria Clinic: Opportunities and challenges. *Australasian Psychiatry, 8*(4), 355-357. doi: 10.1046/j.1440-1665.2000.00278.x

Davis, S., & Colton, M. (2013). Effects of testosterone treatment and chest reconstruction surgery on mental health and sexuality in female-to-male transgender people. *International Journal of Sexual Health, 26*(2), 113-128. doi: 10.1080/19317611.2013.833152

de Beauvoir, S. (1972). *The second sex* (M. Parshley, Trans.). London: Jonathan Cape Ltd.

de Cuypere, G., Elaut, E., Heylens, G., Van Maele, G., Selvaggi, G., & T'Sjoen, G., et al. (2006). Long-term follow-up: Psychosocial outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies, 15*(2), 126-133. doi: 10.1016/j.sexol.2006.04.002

de Cuypere, G., Knudson, G., & Bockting, W. (n.d.). Response of the World Professional Association for Transgender Health to the proposed DSM 5 criteria for gender incongruence. Retrieved August 29, 2013, from http://www.wpath.org/documents/WPATH%20Reaction%20to%20the%20proposed%20DSM%20-%20Final.pdf

de Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., . . . Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679-690. doi: 10.1007/s10508-005-7926-5

de Cuypere, G., & Vercruysse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH standards of care. *International Journal of Transgenderism, 11*(3), 194-205. doi: 10.1080/15532730903383781

de Mello, D. (2007). The language of arts in a narrative inquiry landscape. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 203-223). California: Sage Publications, Inc.

de Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and preserve fertility in transsexual women. *International Journal of Transgenderism, 6*(3). Retrieved from http://www.iiav.nl/ezines/web/ijt/97-03/numbers/symposion/ijtvo06no03_02.htm

de Vries, A., Steensma, T., Doreleijers, T., & Cohen-K. (2010). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine, 8*(8), 2276-2283. doi: 10.1111/j.1743-6109.2010.01943.x

Dean, L., Meyer, I., Robinson, K., Sell, R., Sember, R., & Silenzio, V. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4*(3), 102-151. doi: 10.1023/A:1009573800168

Denny, D. (2004). Changing models of transsexualism. *Journal of Gay & Lesbian Psychotherapy, 8*(1), 25-40. Retrieved from http://www.tandfonline.com

Denny, D., Green, J., & Cole, S. (2007). Gender variability: Transsexuals, crossdressers, and others. In M. Tepper & A. Fuglsang Owens (Eds.), *Sexual health* (Vol. 4, pp. 153-187). Westport, Conn.: Praeger Publishers.

Denzin, N., & Lincoln, Y. (Eds.). (2005). *The Sage handbook of qualitative research* (3rd ed.). California: Sage Publications, Inc.

Department of Defence. (2011). Understanding transitioning gender in the workplace. Retrieved December 4, 2013, from https://www.defglis.com.au/resources/UnderstandingTransition.pdf

Department of Defence. (n.d.). The defence values. Retrieved July 24, 2015, from http://www.defence.gov.au/publications/defence_values.pdf

Department of Foreign Affairs and Trade. (2011). Getting a passport made easier for sex and gendeer diverse people. Retrieved December 19, 2014, from http://www.foreignminister.gov.au/releases/Pages/2011/kr_mr_110914b.aspx?ministerid=2

Derrida, J. (1995). *Points...interviews, 1974-1994*. California: Stanford University Press.

Descartes, R. (2007). Meditations. In B. Gertler & L. Shapiro (Eds.), *Arguing about the mind* (pp. 164-169). New York: Routledge.

Deutsch, M., Green, J., Keatley, J., Mayer, G., Hastings, J., & Hall, A. (2013). Electronic medical records and the transgender patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group. *Journal of the American Medical Informatics Association, 20*(4), 700-703. doi: 10.1136/amiajnl-2012-001472

Devor, H. (1997). "More than manly women: How female-to-male transsexuals reject lesbian identities". In B. Bullough, V. Bullough & J. Elias (Eds.), *Gender blending* (pp. 87-102). New York: Prometheus.

Dewey, J. (2008). Knowledge legitimacy: How trans-patient behavior supports and challenges current medical knowledge. *Qualitative Health Research, 18*(10), 1345-1355. doi: 10.1177/1049732308324247

Dewey, J. (2013). Challenges of implementing collaborative models of decision making with trans-identified patients. *Health Expectations, 18*(5), 1508-1518. doi: 10.1111/hex.12133

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. California: Academic Press.

Diamond, M. (2005). Transsexuality, intersexuality and ethics: First - do no harm. In L. May (Ed.), *Transgenders and intersexuals: Everything you ever wanted to know but couldn't think of the question* (pp. 72-94). South Austrlalia: East Street Publications.

Discrimination Act. (1991) (ACT). Austl.

Djordjevic, M., Stanojevic, D., & Bizic, M. (2011). Rectosigmoid vaginoplasty: Clinical experience and outcomes in 86 cases. *The Journal of Sexual Medicine, 8*(12), 3487-3494. doi: 10.1111/j.1743-6109.2011.02494.x

Dohler, K., Coquelin, A., Davis, F., Hines, M., Shryne, J., & Gorski, R. (1982). Differentiation of the sexually dimorphic nucleus in the preoptic area of the rat brain is determined by the perinatal hormone environment. *Neuroscience Letters, 33*(3), 295-298. doi: 10.1016/0304-3940(82)90388-3

Doidge, N. (2007). *The brain that changes itself*. Melbourne: Scribe Publications.

Downe-Wamboldt, B. (1992). Content analysis: Method, applications, and issues. *Health Care for Women International, 13*(3), 313-321. doi: 10.1080/07399339209516006

Dozier, R. (2005). Beards, breasts, and bodies: Doing sex in a gendered world. *Gender & Society, 19*(3), 297-316. doi: 10.1177/0891243204272153

Drescher, J. (2010). Transsexualism, gender identity disorder and the DSM. *Journal of Gay & Lesbian Mental Health, 14*(2), 109-122. doi: 10.1080/19359701003589637

Duisin, D., Rakic, Z., Nikolic-Balkoski, G., & Cavic, T. (2002). Monitoring of quality of life and outcomes in transsexuals before and after sex-change treatment. *European Psychiatry, 17*(Supplement 1), 208. doi: 10.1016/S0924-9338(02)80890-2

Dunne, M. (2002). Sampling considerations. In M. Wiederman & B. Whitley (Eds.), *Handbook for conducting research on human sexuality*. New Jersey: Lawrence Erlbaum Associates, Inc., Publishers.

Dwyer, S., & Buckle, J. (2009). The space between: On being an insider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63. Retrieved from http://socialiststudies.com

Dziengel, L. (2014). Renaming, reclaiming, renewing the self: Intersections of gender, identity, and health care. *Affilia, 29*(1), 105-110. doi: 10.1177/0886109913510660

Ekins, R., & King, D. (1999). Towards a sociology of transgendered bodies. *The Sociological Review, 47*(3), 580-602. doi: 10.1111/1467-954X.00185

Eldh, J., Berg, A., & Gustafsson, M. (1997). Long term follow up after sex reassignment surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery, 31*(1), 39-45. doi: 10.3109/02844319709010503

Ellingson, L. (2006). Embodied knowledge: Writing researchers' bodies into qualitative health research. *Qualitative Health Research, 16*(2), 298-310. doi: 10.1177/1049732305281944

Ellingson, L. (2008). Embodied knowledge. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1, pp. 244-245). Los Angeles: SAGE.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x

Emanuel, L., Ferris, D., von Gunten, C., & Von Roenn, J. (2011). Loss, grief, and bereavement in the setting of cancer. Retrieved May 15, 2011, from http://www.medscape.com/viewarticle/739523

Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy, 7*(3), 1-12. doi: 10.1300/J085V07N03_01

Equal Opportunity (Gender Identity and Sexual Orientation) Act. (2000) (Vic). Austl.

Equal Opportunity Act. (1984) (WA). Austl.

Equal Opportunity Act. (1995) (Vic). Austl.

Equality and Human Rights Commission. (2012). Technical note: Measuring gender identity. Retrieved October 16, 2012, from

http://www.equalityhumanrights.com/uploaded_files/technical_note_final.pdf

Erikson, E. (1980). *Identity and the life cycle*. USA: W. W. Norton & Company, Inc.

Ettner, R., & Monstrey, S. (Eds.). (2007). *Principles of transgender surgery and medicine*. New York: The Haworth Press, Inc.

Fay, B. (1996). *Contemporary philosophy of social science*. Oxford: Blackwell Publishers.

Featherstone, M. (1999). Body modification: An introduction. *Body & Society, 5*(2-3), 1-13. doi: 10.1177/1357034x99005002001

Feldman, J., & Goldberg, J. (2006). Transgender primary medical care. *International Journal of Transgenderism, 9*(3-4), 3-34. doi: 10.1300/J485v09n03_02

Fleming, M., MacGowan, B., Robinson, L., Spitz, J., & Salt, P. (1982). The body image of the postoperative female-to-male transsexual. *Journal of Consulting and Clinical Psychology, 50*(3), 461-462. doi: 10.1037/0022-006x.50.3.461

Fong Ha, J., & Longnecker, N. (2010). Doctor-patient communication: A review. *The Ochsner Journal, 10*(1), 38-43. doi: doi:10.1043/TOJ-09-0040.1

Foster, H. (Ed.). (1988). *Vision and visuality*. Seattle: Bay Press.

Foucault, M. (1969/1971). *The archaeology of knowledge and the discourse on language* (A. Sheridan Smith, Trans.). New York: Pantheon books.

Foucault, M. (1975). *The birth of the clinic: An archaeology of medical perception* (A. M. Sheridan Smith, Trans.). New York: Vintage Books.

Foucault, M. (1998). *The will to knowledge: The history of sexuality* (R. Hurley, Trans. Vol. 1). London: Penguin Books.

Foucault, M. (2003). *Abnormal: Lectures at the College of France 1974-1975* (G. Burchell, Trans.). New York: Picador.

Frank, A. (1995). *The wounded storyteller*. Chicago: The University of Chicago Press.

Fulton, G., Madden, C., & Minichiello, V. (1996). The social construction of anticipatory grief. *Social Science & Medicine, 43*(9), 1349-1358. doi: 10.1016/0277-9536(95)00447-5

Gayatri, R. (2010). *With respect to sex : Negotiating Hijra identity in South India*. Chicago: University of Chicago Press.

Gender Identity Research and Education Society. (2011). The number of gender variant people in the UK - Update 2011. Retrieved August 7, 2013, from http://www.gires.org.uk/assets/Research-Assets/Prevalence2011.pdf

Gender Reassignment Act. (2000) (WA). Austl.

Gergen, K., & Gergen, M. (1983). Narratives of the self. In T. Sarbin & K. Schiebe (Eds.), *Studies in social identity* (pp. 254-273). New York: Praeger.

Gerrish, K., & Lacey, A. (Eds.). (2010). *The research process in nursing* (6th ed.). Chichester: Blackwell Publishing.

Gilbert, J. (1920). Homo-sexuality and its treatment. *The Journal of Nervous and Mental Disease, 52*(4), 297-322. Retrieved from http://journals.lww.com

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New Jersey: Prentice-Hall Inc.

Gómez-Gil, E., Zubiaurre-Elorza, L., Esteva de Antonio, I., Guillamon, A., & Salamero, M. (2014). Determinants of quality of life in Spanish transsexuals attending a gender unit before genital sex reassignment surgery. *Quality of Life Research, 23*(2), 669-676. doi: 10.1007/s11136-013-0497-3

Grady, C. (2001). Money for research participation: Does it jeopardize informed consent? *American Journal of Bioethics, 1*(2), 40-44. doi: 10.1162/152651601300169031

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. doi: 10.1016/j.nedt.2003.10.001

Grbich, C. (2007). *Qualitative data analysis: An introduction*. London: SAGE Publications.

Green, J. (2013). Look! No, don't! The invisibility dilemma for transsexual men. In M. Adams, W. Blumenfeld, C. Castañeda, H. Hackman, M. Peters & X. Zúñiga (Eds.), *Readings for diversity and social justice* (pp. 453-455). New York: Routledge.

Green, R., Williams, K., & Goodman, M. (1982). Ninety-nine "tomboys" and "non-tomboys": Behavioral contrasts and demographic similarities. *Archives of Sexual Behavior, 11*(3), 247-266. Retrieved from http://link.springer.com

Guba, E., & Lincoln, Y. (2004). Competing paradigms in qualitative research: Theories and issues. In S. Hesse-Biber & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice* (pp. 1-17). New York: Oxford University Press.

Gubrium, J., & Holstein, J. (2009). *Analyzing narrative reality*. California: SAGE Publications.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. doi: 10.1177/1525822x05279903

Haas, A., Rodgers, P., & Herman, J. (2014). Suicide attempts among transgender and gender non-conforming adults: Findings of the national transgender discrimination survey. Retrieved October 13, 2014, from http://escholarship.org/uc/item/8xg8061f#page-1

Hagen, D. B., & Galupo, M. P. (2014). Trans* individuals' experiences of gendered language with health care providers: Recommendations for practitioners. *International Journal of Transgenderism, 15*(1), 16-34. doi: 10.1080/15532739.2014.890560

Hakeem, A. (2008). Changing sex or changing minds: Specialist psychotherapy and transsexuality. *Group Analysis, 41*(2), 182-196. doi: 10.1177/0533316408089883

Hamburger, C., Stürup, G., & Dahl-Iversen, E. (1953). Transvestism: Hormonal, psychiatric, and surgical treatment. *Journal of the American Medical Association, 152*(5), 391-396. doi: 10.1001/jama.1953.03690050015006

Hammersley, M. (2008). *Questioning qualitative inquiry: Critical essays*. California: SAGE Publications.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. London: Routledge.

Haraldsen, I., & Dahl, A. (2000). Symptom profiles of gender dysphoric patients of transsexual type compared to patients with personality disorders and healthy adults. *Acta Psychiatrica Scandinavica, 102*(4), 276-281. doi: 10.1034/j.1600-0447.2000.102004276.x

Hardy, S., Gregory, S., & Ramjeet, J. (2009). An exploration of intent for narrative methods of inquiry. *Nurse Researcher, 16*(4), 7-19. Retrieved from http://rcnpublishing.com

Hare, L., Bernard, P., Sánchez, F., Baird, P., Vilain, E., Kennedy, T., & Harley, V. (2009). Androgen receptor repeat length polymorphism associated with male-to-female transsexualism. *Biological Psychiatry, 65*(1), 93-96. doi: 10.1016/j.biopsych.2008.08.033

Harwood, N. (2013). *Administrative violence: Trans lives and the biopoliitics of classifications of sex and gender in Australia (Unpublished honours dissertation)*. Southern Cross University, Lismore, New South Wales.

Harwood, N., & Vick, M. (2012). *Exploring power relations within a medical model of health: Towards a socio-cultural analysis (Oral)*. Paper presented at the Queensland Transgender, Sistergirl and Gender Diverse Conference, Cairns Queensland. Retrieved from http://www.transconference.org.au

Hembree, W., Cohen-Kettenis, P., Delemarre-van de Waal, H., Gooren, L., Meyer III, W., Spack, N., . . . Montori, V. (2009). Endocrine treatment

of transsexual persons: An Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132-3154. doi: 10.1210/jc.2009-0345

Hesse-Biber, S., & Leavy, P. (Eds.). (2004). *Approaches to qualitative research: A reader on theory and practice*. New York: Oxford University Press.

Hewitt, J., Campbell, P., Kasiannan, P., FGrover, S., Newman, L., & Warne, G. (2012). Hormone treatment of gender identity disorder in a chort of children and adolescents. *Medical Journal of Australia, 196*(9), 578-581. doi: 10.5694/mja12.10222

High Court of Australia. (2011). [Press release about court judgements]. Retrieved January 3, 2013, from http://www.hcourt.gov.au/assets/publications/judgment-summaries/2011/hca42-2011-10-06.pdf

Hill, D., & Willoughby, B. (2005). The development and validation of the genderism and transphobia scale. *Sex Roles, 53*(7-8), 531-544. doi: 10.1007/s11199-005-7140-x

Hines, S. (2007). *TransForming gender: Transgender practices of identity, intimacy and care*. Bristol: The Policy Press.

Hirschauer, S. (1992). The meanings of 'transsexuality'. In J. Lachmund & G. Stollberg (Eds.), *The social construction of illness* (pp. 125-132). Stuttgart: Franz Steiner Verlag.

Hirschauer, S. (1998). Performing sexes and genders in medical practices. In M. Berg & A. Mol (Eds.), *Differences in medicine: Unraveling*

practices, techniques, and bodies (pp. 13-27). USA: Duke University Press.

Holloway, I., & Freshwater, D. (2007). *Narrative research in nursing*. Oxford: Blackwell Publishing.

Horsburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing, 12*(2), 307-312. doi: 10.1046/j.1365-2702.2003.00683.x

Husakouskaya, N. (2013). Rethinking gender and human rights through transgender and intersex experiences in South Africa. *Agenda, 27*(4), 10-24. doi: 10.1080/10130950.2013.860268

Hyde, Z., Doherty, M., Tilley, P., McCaul, K., Rooney, R., & Jancey, J. (2014). The first Australian national trans mental health study: Summary of results. Retrieved March 2nd, 2015, from http://www.beyondblue.org.au/docs/default-source/research-project-files/bw0274.pdf?sfvrsn=2

Imber-Black, E. (1998). *The secret life of families*. New York: Bantam Books.

Intersex Society of North America. (2008a). What's wrong with the way intersex has traditionally been treated? Retrieved May 15, 2011, from http://www.isna.org/faq/concealment

Intersex Society of North America. (2008b). Who was David Reimer (also, sadly, known as "John/Joan")? Retrieved April 26, 2010, from http://www.isna.org/faq/reimer

Irwin, R. (2002). *Psychosexual nursing*. London: Whurr Publishers.

Israel, G. (2004). Supporting transgender and sex reassignment issues. *Journal of Couple & Relationship Therapy, 3*(2-3), 53-63. doi: 10.1300/J398v03n02_06

James, T., & Platzer, H. (1999). Ethical considerations in qualitative research with vulnerable groups: Exploring lesbians' and gay men's experiences of health care - a personal perspective. *Nursing Ethics, 6*(1), 73-81. doi: 10.1177/096973309900600108

Jeffreys, S. (2002). FTM transsexualism and grief. Retrieved July 31, 2015, from http://www.feminist-reprise.org/docs/jeffreysftm.htm

Jenner, C. (2010). Transsexual primary care. *Journal of the American Academy of Nurse Practitioners, 22*(8), 403-408. doi: 10.1111/j.1745-7599.2010.00532.x

Jillings, C. (1985). Loss and grief: Unravelling two complex phenomena. *Critical Care Nurse, 5*(5), 7-9. Retrieved from http://ccn.aacnjournals.org/

Johnson, A. (2015). Normative accountability: How the medical model influences transgender identities and experiences. *Sociology Compass, 9*(9), 803-813. doi: 10.1111/soc4.12297

Johnson, J. (2001). In-depth interviewing. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 103-119). California: SAGE Publications Inc.

Johnson, K. (2007). Changing sex, changing self: Theorizing transitions in embodied subjectivity. *Men and Masculinities, 10*(1), 54-70. doi: 10.1177/1097184X07299330

Jokić-Begić, N., Korajlija, A., & Jurin, T. (2014). Psychosocial adjustment to sex reassignment surgery: A qualitative examination and personal experiences of six transsexual persons in Croatia. *The Scientific World Journal, 2014*, 1-12. doi: 10.1155/2014/960745

Jones, L., Reid, R., di Ceglie, D., Dalrymple, J., Gooren, L., & Green, R., et al. (2008). Transsexualism: The current medical viewpoint. Retrieved December 14, 2009, from http://www.gendercentre.org.au/pdf/fact-sheets/transsexualism-the-current-medical-viewpoint.pdf

Jones, T., del Pozo de Bolger, A., Dune, T., Lykins, A., & Hawkes, G. (2015). *Female-to-male (FtM) transgender people's experiences in Australia : A national study.* Cham, DEU: Springer International Publishing.

Josselson, R. (2006). Narrative research and the challenge of accumulating knowledge. *Narrative Inquiry, 16*(1), 3-10. doi: 10.1075/ni.16.1.03jos

Karpel, L., Gardel, B., Revol, M., Brémont-Weil, C., Ayoubi, J., & Cordier, B. (2015). Bien-être psychosocial postopératoire de 207 transsexuels. *Annales Médico-psychologiques, revue psychiatrique, 173*(6), 511-519. doi: 10.1016/j.amp.2012.01.021

Kaufmann, J. (2010). Trans-representation. *Qualitative Inquiry, 16*(2), 104-115. doi: 10.1177/1077800409350699

Kearney, K., & Hyle, A. (2004). Drawing out emotions: The use of participant-produced drawings in qualitative inquiry. *Qualitative Research, 4*(3), 361-382. doi: 10.1177/1468794104047234

Kellett, U. (1997). Heideggerian phenomenology: an approach to understanding family caring for an older relative. *Nursing Inquiry, 4*(1), 57-65. doi: 10.1111/j.1440-1800.1997.tb00138.x

Kelly, M. (1985). Loss and grief reactions as responses to surgery. *Journal of Advanced Nursing, 10*(6), 517-525. doi: 10.1111/j.1365-2648.1985.tb00542.x

King, N. (1998). Template analysis. In G. Symon & C. Cassell (Eds.), *Qualitative methods and analysis in organizational research* (pp. 118-134). London: SAGE Publications.

Kleinman, A., & Hall-Clifford, R. (2010). Chronicity-time, space, and culture. In L. Manderson & C. Smith-Morris (Eds.), *Chronic conditions, fluid states: Chronicity and the anthropology of illness* (pp. 247-252). New Jersey: Rytgers University Press.

Koken, J. A., Bimbi, D. S., & Parsons, J. T. (2009). Experiences of familial acceptance–rejection among transwomen of color. *Journal of Family Psychology, 23*(6), 853-860. doi: 10.1037/a0017198

Kong, T., Mahoney, D., & Plummer, K. (2001). Queering the interview. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: Context & method*. California: Sage Publications, Inc.

Korell, S., & Lorah, P. (2007). An overview of affirmative psychotherapy and counseling with transgender clients. In K. Bieschke, R. Perez & K. DeBord (Eds.), *Handbook of counseling and psycotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 271-288). Washington: American Psychological Association.

Kruijver, F., Zhou, J., Pool, C., Hofman, M., Gooren, L., & Swaab, D. (2000). Male-to-female transsexuals have female neuron numbers in a limbic nucleus. *Journal of Clinical Endocrinology and Metabolism, 85*(5), 2034-2041. doi: 10.1210/jc.85.5.2034

Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M., & Birkhäuser, M. (2009). Quality of life 15 years after sex reassignment surgery for

transsexualism. *Fertility and Sterility, 92*(5), 1685-1689. doi: 10.1016/j.fertnstert.2008.08.126

Kuvalanka, K. A., Weiner, J. L., & Mahan, D. (2014). Child, family, and community transformations: Findings from interviews with mothers of transgender girls. *Journal of GLBT Family Studies*, null-null. doi: 10.1080/1550428X.2013.834529

Kvale, S. (1992). Postmodern psychology: A contradiction in terms? In S. Kvale (Ed.), *Psychology and postmodernism* (pp. 31-57). London: SAGE publications Ltd.

Kvale, S. (2002). The social construction of validity. In N. Denzin & Y. Lincoln (Eds.), *The qualitative inquiry reader* (pp. 299-325). California: Sage Publications.

Labov, W., & Waletzky, J. (1967). Narrative analysis: Oral versions of personal experience. Retrieved February 12, 2010, from http://www.clarku.edu/~mbamberg/LabovWaletzky.htm

Landén, M., Wålinder, J., Hambert, G., & Lundström, B. (1998). Factors predictive of regret in sex reassignment. *Acta Psychiatrica Scandinavica, 97*(4), 284-289. doi: 10.1111/j.1600-0447.1998.tb10001.x

Lane, R. (2008). Truth, lies and trans science. *Archives of Sexual Behavior, 37*(3), 453-456. doi: 10.1007/s10508-008-9336-y

Lane, R. (2011). *Trans, science and society: The politics of knowledge and the brain sex theory of trans (Doctoral dissertation).* Retrieved from Latrobe University Research Online Repository

Langer, S. (2014). Our body project: From mourning to creating the transgender body. *International Journal of Transgenderism, 15*(2), 66-75. doi: 10.1080/15532739.2014.899175

Lawrence, A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299-315. doi: 10.1023/A:1024086814364

Lawrence, A. (2007). A critique of the brain-sex theory of transsexualism. Retrieved May 6, 2010, from http://www.annelawrence.com/twr/brain-sex_critique.html

Lawrence, A. (2011). Autogynephilia: An underappreciated paraphilia. *Advances in Psychosomatic Medicine, 31*, 135-148. doi: 10.1159/000328921

Leclère, F., Casoli, V., & Weigert, R. (2015). Vaginoplasty in male-to-female transsexual surgery: A training concept incorporating dissection room experience to optimize functional and cosmetic results. *The Journal of Sexual Medicine, 12*(10), 2074-2083. doi: 10.1111/jsm.12996

Lee, R., & Renzetti, C. (1990). The problems of researching sensitive topics: An overview and introduction. *American Behavioral Scientist, 33*(5), 510-528. doi: 10.1177/0002764290033005002

Lerner, H. (1993). *The dance of deception: Pretending and truth-telling in women's lives*. London: HarperCollins Publishers.

Lesser, J. (1999). When your son becomes your daughter: A mother's adjustment to a transgender child. *Families in Society, 80*(2), 182-189. doi: 10.1606/1044-3894.660

Lev, A. (2006). Transgender emergence within families. In D. F. Morrow & L. Messinger (Eds.), *Sexual orientation & gender expression in social work practice*. New York: Columbia University Press.

Levitt, H., & Ippolito, M. (2014). Being transgender: The experience of transgender identity development. *Journal of Homosexuality, 61*(12), 1727-1758. doi: 10.1080/00918369.2014.951262

Lewis, C. S. (1946). *The abolition of man*. London: Geoffrey Bles.

Liamputtong, P. (2009). *Qualitative research methods* (3rd ed.). South Melbourne: Oxford University Press.

Liamputtong Rice, P., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. South Melbourne: Oxford University Press.

Lincoln, Y., Lynham, S., & Guba, E. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. Denzin & Y. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 97-128). Los Angeles: SAGE Publications, Inc.

Love, A. (2007). Progress in understanding grief, complicated grief, and caring for the bereaved. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 27*(1), 73-83. Retrieved from http://www.contemporarynurse.com/

Lupton, D. (2003). The social construction of medicine and the body. In G. Albrecht, R. Fitzpatrick & S. Scrimshaw (Eds.), *Social studies in health and medicine* (pp. 50-63). London: SAGE Publications Ltd.

Lupton, D. (2012). *Medicine as culture: Illness, disease and the body* (3rd ed.). London: SAGE Publications Ltd.

Lyons, N. (2007). Narrative inquiry: Possible future inflence. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 600-631). California: Sage Publications, Inc.

Maggs-Rapport, F. (2001). 'Best research practice': In pursuit of methodological rigour. *Journal of Advanced Nursing, 35*(3), 373-383. doi: 10.1046/j.1365-2648.2001.01853.x

Mander, R., & Page, M. (2012). Midwifery and the LGBT midwife. *Midwifery, 28*(1), 9-13. doi: 10.1016/j.midw.2011.03.008

Mapstone, J., Elbourne, D., & Roberts, I. (2007). Strategies to improve recruitment to research studies. *Cochrane Database of Systematic Reviews (Online)*. doi: 10.1002/14651858.MR000013.pub3.

Marriage Act. (1961) (Clth). Austl.

Martin, J., & Dean, L. (1993). Developing a community sample of gay men for an epidemiological study of AIDS. In C. Renzetti & R. Lee (Eds.), *Researching sensitive topics* (pp. 82-99). London: SAGE Publications.

Martin, J., & Yonkin, D. (2006). Transgender identity. In D. F. Morrow & L. Messinger (Eds.), *Sexual orientation & gender expression in social work practice* (pp. 105-128). New York: Columbia University Press.

Mason-Schrock, D. (1996). Transsexuals' narrative construction of the "true self"*. *Social Psychology Quarterly, 59*(3), 176-192. Retrieved from http://spq.sagepub.com/

Mate-Kole, C., Freschi, M., & Robin, A. (1990). A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals. *The British Journal of Psychiatry, 157*, 261-264. doi: 10.1192/bjp.157.2.261

McCabe, A. (2008). Narrative inquiry. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 2, pp. 541-545). Los Angeles: SAGE.

McCabe, C. (2004). Nurse-patient communication: An exploration of patients' experiences. *Journal of Clinical Nursing, 13*(1), 41-49. doi: 10.1111/j.1365-2702.2004.00817.x

McKitrick, J. (2007). Gender identity disorder. In H. Kincaid & J. Mckitrick (Eds.), Establishing medical reality: Essays in the metaphysics and epistemology of biomedical science (pp. 137-148). Dordrecht: Kluwer Academic Publishers. Retrieved from http://QUT.eblib.com.au/patron/FullRecord.aspx?p=371787.

McLemore, K. (2015). Experiences with misgendering: Identity misclassification of transgender spectrum individuals. *Self and Identity, 14*(1), 51-74. doi: 10.1080/15298868.2014.950691

McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). Trans mental health study 2012. Retrieved April 16, 2013, from http://www.scottishtrans.org/Uploads/Resources/trans_mh_study.pdf

McNeil, J., Bailey, L., Ellis, S., & Regan, M. (2013). Speaking from the margins: Transgender health and wellbeing in Ireland. Retrieved March 5, 2014, from http://www.teni.ie/news-post.aspx?contentid=1027

Meese, P. (1997). The role of the general practitioner in the care of the transgender patient. *Venereology, 10*(3), 154-157. Retrieved from http://search.informit.com.au/

Merleau-Ponty, M. (2004). *Maurice Merleau-Ponty: Basic writings*. London: Routledge.

Merleau-Ponty, M. (2005). The experience of the body and classical psychology. In M. Fraser & M. Greco (Eds.), *The body: A reader* (pp. 52-71). London: Routledge.

Merleau-Ponty, M. (2012). *Phenomenology of perception* (D. Landes, Trans.). New York: Routledge.

Merryfeather, L., & Bruce, A. (2014). The invisibility of gender diversity: Understanding transgender and transsexuality in nursing literature. *Nursing Forum, 49*(2), 110-123. doi: 10.1111/nuf.12061

Metzl, J. M., & Herzig, R. M. (2007). Medicalisation in the 21st century: Introduction. *The Lancet, 369*(9562), 697-698. doi: 10.1016/S0140-6736(07)60317-1

Meyer, W., Bockting, W., Cohen-Kettenis, P., Coleman, E., Di Ceglie, D., & Devor, H., et al. (2001). The Harry Benjamin International Gender Dysphoria Association's standards of care for gender identity disorders, sixth version. Retrieved December 4, 2009, from http://www.wpath.org/documents2/socv6.pdf

Michel, A., Ansseau, M., Legros, J., Pitchot, W., & Mormont, C. (2002). The transsexual: What about the future? *European Psychiatry, 17*(6), 353-362. doi: 10.1016/S0924-9338(02)00703-4

Minton, H. (1986). Femininity in men and masculinity in women. *Journal of Homosexuality, 13*(1), 1-21. doi: 10.1300/J082v13n01_01

Mishler, E. (1986). The analysis of interview-narratives. In T. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 233-255). New York: Praeger Publishers.

Mishler, E. (1995). Models of narrative analysis: A typology. *Journal of Narrative and Life History, 5*(2), 87-123.

Mizock, L., & Lewis, T. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse, 8*(3), 335-354. doi: 10.1080/10926790802262523

Money, J. (1994). The concept of gender identity disorder in childhood and adolescence after 39 years. *Journal of Sex & Marital Therapy, 20*(3), 163-177. doi: 10.1080/00926239408403428

Morgan, S., & Stevens, P. (2012). Transgender identity development as represented by a group of transgendered adults. *Issues in Mental Health Nursing, 33*(5), 301-308. doi: doi:10.3109/01612840.2011.653657

Morse, J. (1991). *Qualitative nursing research: A contemporary dialogue* (Rev. ed.). California: Sage Publications.

Morse, J., Barrett, M., Mayan, M., Olsin, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal For Qualitative Methodology, 1*(2), 13-22. Retrieved from http://ejournals.library.ualberta.ca/index.php/IJQM/

Namaste, V. (2000). *Invisible lives: The erasure of transsexual and transgendered people*. Chicago: The University of Chicago Press.

National Health and Hospitals Reform Commission. (2008). National GLBT health alliance. Retrieved June 15, 2011, from

http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/124/$FILE/124%20-%20SUBMISSION%20-%20National%20Gay,%20Lesbian,%20Bisexual,%20Transgender%20Health%20Alliance.pdf

National LGBTI Health Alliance. (2012). Diversity in health: Improving the health and well-being of transgender, intersex and other sex and gender diverse Australians. Retrieved November 28, 2012, from http://www.lgbtihealth.org.au/sites/default/files/Diversity%20In%20Health%20Report%20FINALOnline.pdf

Neisser, U. (1994). Self-narratives: True and false. In U. Neisser & R. Fivush (Eds.), *The remembering self: Construction and accuracy in the self-narrative* (pp. 1-18). United States of America: Cambridge University Press.

Nelson, L., Whallett, E. J., & McGregor, J. C. (2009). Transgender patient satisfaction following reduction mammaplasty. *Journal of Plastic, Reconstructive & Aesthetic Surgery, 62*(3), 331-334. doi: 10.1016/j.bjps.2007.10.049

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research, 15*(9), 1447-1457. doi: 10.1007/s11136-006-0002-3

NHMRC. (2007). National statement on ethical conduct in human research. Retrieved February 17, 2012, from http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72-jul09.pdf

Nizette, D. (2007). Mental health across the lifespan. In R. Elder, K. Evans & D. Nizette (Eds.), *Psychiatric and mental health nursing* (pp. 113-130). Sydney: Elsevier.

Nordgren, S., & Fridlund, B. (2001). Patients' perceptions of self-determination as expressed in the context of care. *Journal of Advanced Nursing, 35*(1), 117-125. Retrieved from http://onlinelibrary.wiley.com

Nordmarken, S. (2014). Becoming ever more monstrous: Feeling transgender in-betweenness. *Qualitative Inquiry, 20*(1), 37-50. doi: 10.1177/1077800413508531

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology, 11*(4), 327-344. doi: 10.1080/13645570701401305

NSW Registrar of Births Deaths and Marriages v. Norrie, No. S273/2013 HCA (2014).

Olsson, S., & Möller, A. (2006). Regret after sex reassignment surgery in a male-to-female transsexual: A long-term follow-up. *Archives of Sexual Behavior, 35*(4), 501-506. doi: 10.1007/s10508-006-9040-8

Oswald, R. (2001). Religion, family, and ritual: The production of gay, lesbian, bisexual, and transgender outsiders-within. *Review of Religious Research, 43*(1), 39-50. doi: 10.2307/3512242

Oxman, T., Barrett, J., Freeman, D., & Manheimer, E. (1994). Frequency and correlates of adjustment disorder related to cardiac surgery in older

patients. *Psychosomatics, 35*(6), 557-568. doi: 10.1016/s0033-3182(94)71724-2

Parker, R. (2012). Stigma, prejudice and discrimination in global public health. *Cadernos de Saúde Pública, 28*, 164-169.

Parola, N., Bonierbale, M., Lemaire, A., Aghababian, V., Michel, A., & Lançon, C. (2010). Study of quality of life for transsexuals after hormonal and surgical reassignment. *Sexologies, 19*(1), 24-28. doi: 10.1016/j.sexol.2009.05.003

Parsons, T. (1951). *The social system*. London: Collier-MacMillan Limited.

Pauly, I., & Lindgren, T. (1977). Body image and gender identity. *Journal of Homosexuality, 2*(2), 133-142. doi: 10.1300/J082v02n02_04

Pillow, W. (1997). Exposed methodology: The body as a deconstructive practice. *International Journal of Qualitative Studies in Education, 10*(3), 349-363. doi: 10.1080/095183997237160

Pillow, W. (2003a). 'Bodies are dangerous': Using feminist genealogy as policy studies methodology. *Journal of Education Policy, 18*(2), 145-159. doi: 10.1080/0268093022000043083

Pillow, W. (2003b). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education, 16*(2), 175-196. doi: 10.1080/0951839032000060635

Pinnegar, S., & Daynes, J. (2007). Locating narrative inquiry historically. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 3-34). California: Sage Publications, Inc.

Pitts, M., Couch, M., Mulcare, H., Croy, S., & Mitchell, A. (2009). Transgender people in Australia and New Zealand: Health, well-being and access to health services. *Feminism & Psychology, 19*(4), 475-495. doi: 10.1177/0959353509342771

Polit, D., & Beck, C. (2006). *Essentials of nursing research: Methods, appraisal, and utilization* (6th ed.). Sydney: Lippincott, Williams & Wilkins.

Polkinghorne, D. (1992). Postmodern epistemology of practice. In S. Kvale (Ed.), *Psychology and postmodernism* (pp. 146-165). London: SAGE Publications Ltd.

Popkewitz, T. (1998). *Struggling for the soul: The politics of schooling and the construction of the teacher*. New York: Teachers' College Press.

Prosser, J. (2005). *Light in the dark room: Photography and loss*. Minneapolis: University of Minnesota Press.

Rankin, J. (2002). What is narrative? *Concrescence: The Australasian Journal of Process Thought, 3*, 1-12. Retrieved from http://concrescence.org

Registration of Births Deaths and Marriages Act. (1963) (NF). Austl.

Religion Dispatches. (2009, September 2). Transgender and christian: Finding identity. Retrieved June 2, 2014, from http://religiondispatches.org/transgender-and-christian-finding-identity/

Renzetti, C., & Lee, R. (Eds.). (1993). *Researching sensitive topics*. California: SAGE Publications, Inc.

Rich, J., & Grey, C. (2003). Qualitative research on trauma surgery: Getting beyond the numbers. *World Journal of Surgery, 27*(8), 957-961. doi: 10.1007/s00268-003-7099-0

Ricoeur, P. (1981a). *Hermeneutics and the human sciences* (J. Thompson, Trans.). Cambridge: Cambridge University Press.

Ricoeur, P. (1981b). Narrative time. In W. Mitchell (Ed.), *On Narrative* (pp. 165-186). Chicago: The University of Chicago Press.

Ricoeur, P. (1984). *Time and narrative* (K. McLaughlin & D. Pellauer, Trans. Vol. 1). Chicago: University of Chicago Press.

Ricoeur, P. (1985). *Time and narrative* (K. McLaughlin & D. Pellauer, Trans. Vol. 2). Chicago: University of Chicago Press.

Ricoeur, P. (1988). *Time and narrative* (K. McLaughlin & D. Pellauer, Trans. Vol. 3). Chicago: University of Chicago Press.

Ricoeur, P. (1991a). Life in quest of narrative. In D. Wood (Ed.), *On Paul Ricoeur: Narrative and interpretation* (pp. 21-33). London: Routledge.

Ricoeur, P. (1991b). Narrative identity. *Philosophy Today, 35*(1), 73-81. Retrieved from http://www.pdcnet.org/philtoday

Ricoeur, P. (1992). *Oneself as another* (K. Blamey, Trans.). Chicago: University of Chicago Press.

Riessman, C. (2008). *Narrative methods for the human sciences*. California: Sage Publications.

Riessman, C., & Speedy, J. (2007). Narrative inquiry in the psychotherapy professions: A critical review. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 426-456). London: SAGE Publications.

Riggs, D., & Due, C. (2013). The health care experiences of people whose gender identity differs from that expected of their natally assigned sex. Retrieved August 30, 2013, from http://www.genderidentityaustralia.com/blog/wp-content/uploads/2013/08/Gender-Identity-Australia-Report.pdf

Roethke, T. (1941). *Open house*. New York: Alfred A Knopf.

Rogers, A. (2007). The unsayable, Lacanian psychoanlaysis, and the art of narrative interviewing. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 99-119). California: Sage Publications, Inc.

Rogers, L. (1999). *Sexing the brain*. London: Weidenfield and Nicolson.

Roller, C., Sedlak, C., & Draucker, C. (2015). Navigating the system: How transgender individuals engage in health care services. *Journal of Nursing Scholarship, 47*(5), 417-424. doi: 10.1111/jnu.12160

Rose, G. (2007). *Visual methodologies: An introduction to the interpretation of visual materials*. London: SAGE Publications Ltd.

Rose, N. (2007). Beyond medicalisation. *The Lancet, 369*(9562), 700-702. doi: 10.1016/S0140-6736(07)60319-5

Rosenblatt, P. C. (1988). Grief: The social context of private feelings. *Journal of Social Issues, 44*(3), 67-78. doi: 10.1111/j.1540-4560.1988.tb02077.x

Ross, M., Wålinder, J., Lundström, B., & Thuwe, I. (1981). Cross-cultural approaches to transsexualism. *Acta Psychiatrica Scandinavica, 63*, 75-82. Retrieved from http://onlinelibrary.wiley.com

Russell, A., & Saebel, J. (1997). Mother-son, mother-daughter, father-son, and father-daughter: Are they distinct relationships? *Developmental Review, 17*(2), 111-147. doi: 10.1006/drev.1996.0431

Saldana, J. (2013). *The coding manual for qualitative researchers* (2nd ed.). Los Angeles: SAGE Publications Ltd.

Salinger, J. (1958). *The catcher in the rye* (2nd ed.). London: Penguin Books.

Sargeant, M. (2005). *Biomedicine and the human condition: Challenges, risks, and rewards*. New York: Cambridge University Press.

Schneider, F., Nehaus, N., Zitzmann, M., Heß, J., Mahler, D., van Ahlen, H., . . . Kliesch, S. (2015). Testicular functions and clinical characterization of patients with gender dysphoria undergoing sex reassignment surgery. *Journal of Sexual Medicine, 12*(11), 2190-2200. doi: 10.1111/jsm.13022

Schrock, D., Reid, L., & Boyd, E. (2005). Transsexuals' embodiment of womanhood. *Gender & Society, 19*(3), 317-335. doi: 10.1177/0891243204273496

Schutz, A. (1970). *Alfred Schutz on phenomenology and social relations: Selected writings*. Chicago: University of Chicago Press.

Scott, J., & Marshall, G. (Eds.). (2009). *Oxford dictionary of sociology* (3rd ed.). New York: Oxford University Press.

Semmer, N., Elfering, A., Jacobshagen, N., Perrot, T., Beehr, T., & Boos, N. (2008). The emotional meaning of instrumental social support. *International Journal of Stress Management, 15*(3), 235-251. doi: 10.1037/1072-5245.15.3.235

Sex and Age Discrimination Legislation Amendment Bill. (2011) ((Clth)). Austl.

Sex Discrimination Act. (1984) (Clth). Austl.

Sex Discrimination Amendment (Sexual Orientation Gender Identity and Intersex Status) Bill. (2013) (Clth). Austl.

Sexual Reassignment (Recognition Certificates) Amendment Bill. (2014) (SA). Austl.

Sexual Reassignment Act. (1988) (SA). Austl.

Shildrick, M. (1999). This body which is not one: Dealing with differences. *Body & Society, 5*(2-3), 77-92. doi: 10.1177/1357034x99005002005

Singh, A., Hays, D., & Watson, L. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development, 89*(1), 20-27. Retrieved from http://onlinelibrary.wiley.com

Singh, A. A., Meng, S. E., & Hansen, A. W. (2014). 'I am my own gender': Resilience strategies of trans youth. *Journal of Counseling & Development, 92*(2), 208-218. doi: 10.1002/j.1556-6676.2014.00150.x

Skinner, D. (2008). Hermeneutics. In L. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (Vol. 1, pp. 385-389). Los Angeles: SAGE.

Smith, E., Jones, T., Ward, R., Dixon, J., Mitchell, A., & Hillier, L. (2014). From blues to rainbows: The mental health and well-being of gender diverse and transgender people in Australia. Retrieved February 18, 2016, from https://www.beyondblue.org.au/docs/default-

source/research-project-files/bw0268-from-blues-to-rainbows-report-final-report.pdf?sfvrsn=2

Smith, J. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being, 2*(1), 3-11. doi: 10.1080/17482620601016120

Smith, Y., van Goozen, S., Kuiper, A., & Cohen-Kettenis, P. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89-99. doi: 10.1017/S0033291704002776

Snell, W., Hawkins, R., & Belk, S. (1988). Stereotypes about male sexuality and the use of social influence strategies in intimate relationships. *Journal of Social and Clinical Psychology, 7*(1), 42-48. doi: 10.1521/jscp.1988.7.1.42

Sobralske, M. (2005). Primary care needs of patients who have undergone gender reassignment. *Journal of the American Academy of Nurse Practitioners, 17*(4), 133-138. doi: 10.1111/j.1041-2972.2005.0021.x

Socarides, C. (1969). The desire for sexual transformation: A psychiatric evaluation of transsexualism. *American Journal of Psychiatry, 125*(10), 1419-1425. Retrieved from http://ajp.psychiatryonline.org/

Sørensen, T., & Hertoft, P. (1980). Sexmodifying operations on transsexuals in Denmark in the period 1950–1977. *Acta Psychiatrica Scandinavica, 61*(1), 56-66. doi: 10.1111/j.1600-0447.1980.tb00565.x

Spade, D. (2003). Resisting medicine, re/modelling gender. *Berkeley Women's Law Journal, 18*, 15-39. Retrieved from http://heinonline.org

Spade, D. (2008). Documenting gender. *The Hastings Law Journal, 59*, 731-842. Retrieved from http://heinonline.org

Spade, D. (2011). *Normal life: Administrative violence, critical trans politics, and the limits of law*. Brooklyn: South End Press.

Sparrowe, R. (2005). Authentic leadership and the narrative self. *The Leadership Quarterly, 16*(3), 419-439. doi: 10.1016/j.leaqua.2005.03.004

Speer, S., & McPhillips, R. (2013). Patients' perspectives on psychiatric consultations in the Gender Identity Clinic: Implications for patient-centered communication. *Patient Education and Counseling, 91*(3), 385-391. doi: 10.1016/j.pec.2012.12.009

St. Pierre, E. (1997). Methodology in the fold and the irruption of transgressive data. *International Journal of Qualitative Studies in Education, 10*(2), 175-189. doi: 10.1080/095183997237278

St. Pierre, E. (2008). Decentering voice in qualitative inquiry. In A. Y. Jackson & L. A. Mazzei (Eds.), *Voice in qualitative inquiry: Challenging conventional, interpretive, and critical conceptions in qualitative research* (pp. 221-236). Hoboken: Routledge.

Stolley, K., & Watson, S. (2012). *Medical tourism*. California: ABC-CLIO.

Sullivan, N. (2008). The role of medicine in the (trans)formation of 'wrong' bodies. *Body & Society, 14*(1), 105-116. doi: 10.1177/1357034x07087533

Teh, Y. (2001). Mak nyahs (male transsexuals) in Malaysia: The influence of culture and religion on their identity. *International Journal of Transgenderism, 5*(3). Retrieved from

http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo05no03_04.htm

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work, 42*(3), 443-460. Retrieved from http://bjsw.oxfordjournals.org

The Australian. (2014, April 17). Nation's transgenders recognised in law. Retrieved April 17, 2014, from http://www.theaustralian.com.au/news/nation/indias-transgenders-recognised-in-law/story-e6frg6nf-1226886986587#

The Royal College of Australasian Physicians. (2015). Sexual orientation, gender identity & intersex rights discussion paper. Retrieved July 4, 2015, from http://www.humanrights.gov.au/sites/default/files/19_Pub_Sub_The%20Royal%20Australasian%20College%20of%20Physicians.pdf

Therapeutic Goods Administration. (2008). Diethylstilboestrol (DES). Retrieved August 22, 2013, from http://www.tga.gov.au/safety/alerts-medicine-des.htm

Tishler, C., & Bartholomae, S. (2002). The recruitment of normal healthy volunteers: A review of the literature on the use of financial incentives. *The Journal of Clinical Pharmacology, 42*(4), 365-375. doi: 10.1177/00912700222011409

Toombs, S. K. (1987). The meaning of illness: A phenomenological approach to the patient-physician relationship. *Journal of Medicine and Philosophy, 12*(3), 219-240. doi: 10.1093/jmp/12.3.219

Trahar, S. (2008). It starts with once upon a time. *Compare, 38*(3), 259-266. doi: 10.1080/03057920802066519

Transgender (Anti-Discrimination and Other Acts Amendment) Act. (1996) (NSW). Austl.

Trevor, M., & Boddy, J. (2013). Transgenderism and Australian social work: A literature review. *Australian Social Work, 66*(4), 555-570. doi: 10.1080/0312407X.2013.829112

Turner, B. (1995). *Medical power and social knowledge*. London: SAGE Publicattions.

Turner, R. (1999). Ordinary people. *Nursing Standard, 14*(1), 22. Retrieved from http://rcnpublishing.com

Udeze, B., Abdelmawla, N., Khoosal, D., & Terry, T. (2008). Psychological functions in male-to-female transsexual people before and after surgery. *Sexual & Relationship Therapy, 23*(2), 141-145. doi: 10.1080/14681990701882077

van Kesteren, P., Gooren, L., & Megens, J. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior, 25*(6), 589-600. Retrieved from http://www.springer.com

Van Wagenen, A., Driskell, J., & Bradford, J. (2013). “I'm still raring to go”: Successful aging among lesbian, gay, bisexual, and transgender older adults. *Journal of Aging Studies, 27*(1), 1-14. doi: 10.1016/j.jaging.2012.09.001

Vance, S., Cohen-Kettenis, P., Drescher, J., Meyer-Bahlburg, H., Pfäfflin, F., & Zucker, K. J. (2010). Opinions about the DSM gender identity

disorder diagnosis: Results from an international survey administered to organisations concerned with the welfare of transgender people. *International Journal of Transgenderism, 12*(1), 1-14. doi: 10.1080/15532731003749087

Vangelisti, A. L. (1994). Family secrets: Forms, functions and correlates. *Journal of Social and Personal Relationships, 11*(1), 113-135. doi: 10.1177/0265407594111007

Vasey, P., & Bartlett, N. (2007). What can the Samoan "fa'afafine" teach us about the western concept of gender identity disorder in childhood? *Perspectives in Biology and Medicine, 50*(4), 481-490. Retrieved from http://muse.jhu.edu/journals/perspectives_in_biology_and_medicine/

Veale, J. (2008). Prevalence of transsexualism among New Zealand passport holders. *Australian and New Zealand Journal of Psychiatry, 42*(10), 887-889. doi: 10.1080/00048670802345490

Virgin Australia. (n.d.). Conditions of carriage. Retrieved October 4, 2015, from http://www.virginaustralia.com/au/en/about-us/legal-policies/conditions-of-carriage/

Vitale, A. (2010). *The gendered self: Further commentary on the transsexual phenomenon*. California: Flyfisher Press.

Warren, C. (2001). Qualitative interviewing. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 83-102). California: Sage Publications Inc.

Warren, C. (2014). Gender reassignment surgery in the 18th century: A case study. *Sexualities, 17*(7), 872-884. doi: 10.1177/1363460714531270

Weber, S. (2008). Visual images in research. In J. Knowles & A. Cole (Eds.), *Handbook of the arts in qualitative research: Perspectives, methodologies, examples, and issues* (pp. 41-53). Los Angeles: Sage Publications.

Weber, S., & Mitchell, C. (1995). *'That's funny, you don't look like a teacher'*. London: The Falmer Press.

Webster's Collegiate Dictionary. (1947). (5th ed.). Springfield: Merriam.

Webster, L., & Mertova, P. (2007). *Using narrative inquiry as a research method.* Retrieved from Electronic Book Library Database.

Wegner, D., & Lane, J. (1995). From secrecy to psychopathology. In J. W. Pennebaker (Ed.), *Emotion, disclosure, & health.* (pp. 25-46). Washington, DC, US: American Psychological Association.

Weiss, M., Ramakrishna, J., & Somma, D. (2006). Health-related stigma: Rethinking concepts and interventions. *Psychology, Health & Medicine, 11*(3), 277-287. doi: 10.1080/13548500600595053

Weyers, S., Elaut, E., de Sutter, P., Gerris, J., T'Sjoen, G., Heylens, G., . . . Verstraelen, H. (2009). Long-term assessment of the physical, mental, and sexual health among transsexual women. *Journal of Sexual Medicine, 6*(3), 752-760. doi: 10.1111/j.1743-6109.2008.01082.x

White, H. (1981). The value of narrativity in the representation of reality. In W. Mitchell (Ed.), *On Narrative* (pp. 1-24). Chicago: The University of Chicago Press.

White Hughto, J., Reisner, S., & Pachankis, J. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and

interventions. *Social Science & Medicine, 147*, 222-231. doi: 10.1016/j.socscimed.2015.11.010

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W. W. Norton & Company.

Whitley, B. (2002). Validity in research. In M. Wiederman & B. Whitley (Eds.), *Handbook for conducting research in human sexuality* (pp. 51-84). New Jersey: Lawrence Erlbaum Associates, Inc., Publishers.

Whitley, C. (2013). Trans-kin undoing and redoing gender: Negotiating relational identity among friends and family of transgender persons. *Sociological Perspectives, 56*(4), 597-621. doi: 10.1525/sop.2013.56.4.597

Whittle, S. (1999a). The becoming man. In K. More & S. Whittle (Eds.), *Reclaiming genders: Transsexual grammars at the fin de siècle* (pp. 15-33). London: Cassel.

Whittle, S. (1999b). Introduction 2. In K. More & S. Whittle (Eds.), *Reclaiming genders: Transsexual grammars at the fin de siècle* (pp. 6-14). London: Cassel.

Widiger, T., & Shea, T. (1991). Differentiation of Axis I and Axis II disorders. *Journal of Abnormal Psychology, 100*(3), 399-406. doi: 10.1037/0021-843X.100.3.399

Williams, C., Weinberg, M., & Rosenberger, J. (2013). Trans men: Embodiments, identities, and sexualities. *Sociological Forum, 28*(4), 719-741. doi: 10.1111/socf.12056

Williamson, C. (2010). Providing care to transgender persons: A clinical approach to primary care, hormones, and HIV management. *Journal*

of the Association of Nurses in AIDS Care, 21(3), 221-229. doi: 10.1016/j.jana.2010.02.004

Willis, K., & Elmer, S. (2011). *Society, culture and health: An introduction to sociology for nurses* (2nd ed.). Melbourne, Vic: Oxford University Press.

Winter, S. (2012). Lost in transition: Transgender people, rights and HIV vulnerability in the Asia-Pacific region. Retrieved February 11, 2013, from http://www.undp.org/content/dam/undp/library/hivaids/Lost%20in%20translation.pdf

Winters, K. (2005). Gender dissonance: Diagnostic reform of gender identity disorder in adults. In D. Karasic & J. Drescher (Eds.), *Sexual and gender diagnoses of the Diagnostic and Statistical Manual (DSM): A reevaluation* (pp. 71-89). New York: The Haworth Press.

Witten, T., Benestad, E., Berger, I., Ekins, R., Ettner, R., Harima, K., . . . Sharpe, A. (2004). Transgender and transsexuality. *Encyclopedia of Sex and Gender.* Retrieved March 12, 2010, from http://www.springerlink.com/content/u4728v26268p2281/fulltext.pdf

Wittgenstein, L. (1953/1967). *Philosophical investigations* (G. Anscombe, Trans.). Oxford: Basil Blackwell.

World Health Organisation. (1978). Declaration of Alma-Ata: International conference on primary health care. Retrieved March 12, 2012, from http://www.who.int/publications/almaata_declaration_en.pdf

World Health Organisation. (1993). The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research. Retrieved

January 18, 2010, from http://www.who.int/classifications/icd/en/GRNBOOK.pdf

WPATH. (2010). WPATH identity recognition statement, 2010. Retrieved July 3, 2015, from http://www.wpath.org/uploaded_files/140/files/Identity%20Recognition%20Statement%206-6-10%20on%20letterhead.pdf

WPATH. (2011a). Standards of care for the health of transsexual, transgender, and gender nonconforming people. Retrieved January 16, 2011, from http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf

WPATH. (2011b). Standards of care v1-6. Retrieved December 11, 2012, from http://www.wpath.org/documents/SOC%20Compilation%20of%201%20through%206.pdf

WPATH. (2015). WPATH statement on legal recognition of gender identity. Retrieved July 3, 2015, from http://www.wpath.org/uploaded_files/140/files/WPATH%20Statement%20on%20Legal%20Recognition%20of%20Gender%20Identity%201-19-15.pdf

Wylie, K., Barrett, J., Besser, M., Bouman, W. P., Bridgman, M., Clayton, A., . . . Rathbone, M. (2014). Good practice guidelines for the assessment and treatment of adults with gender dysphoria. *Sexual & Relationship Therapy, 29*(2), 154-214. doi: 10.1080/14681994.2014.883353

Zamboni, B. (2006). Therapeutic considerations in working with the family, friends, and partners of transgendered individuals. *The Family Journal, 14*(2), 174-179. doi: 10.1177/1066480705285251

Zandvliet, T. (2000). Transgender issues in therapy. In D. Davies & C. Neal (Eds.), *Issues in therapy with lesbian, gay, bisexual, and transgendered clients* (pp. 176-189). Philadelphia: Open University Press.

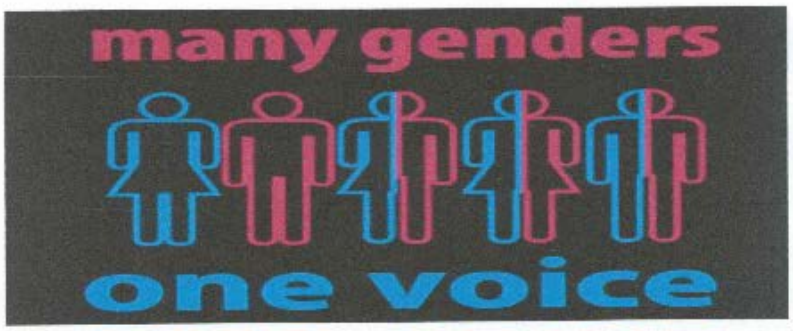
Zhou, J., Hofman, M., Gooren, L., & Swaab, D. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature, 378*(6552), 68-70. doi: 10.1038/378068a0

Zimman, L. (2014). The discursive construction of sex: Remaking and reclaiming the gendered body in talk about genitals among trans men. In L. Zimman, J. Davis & J. Raclaw (Eds.), *Queer excursions: Retheorizing binaries in language, gender, and sexuality* (pp. 13-34). New York: Oxford University Press.

Zola, I. (1972). Medicine as an institution of social control *. *The Sociological Review, 20*(4), 487-504. doi: 10.1111/j.1467-954X.1972.tb00220.x

Appendices

Appendix A: Copyright Permission to use MGOV Logo



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RE: Copyright Permission MGOV Logo

Dear Belinda,

Thank you for your recent enquiry about using the MGOV logo in your PhD in Nursing thesis entitled "Exploring post-operative trans* and gender diverse peoples' perceptions of psychosocial experiences surrounding the surgical process." Your request was considered at the MGOV monthly meeting held on the 4th June 2014 and I am pleased to inform you that all members present (excluding yourself) voted in favour of your request.

Please note that this permission only applies to the image appearing in the thesis document titled above when it is published in both paper and digital formats. No other use of the image is granted.

Thank you for your continued work in the improvement of the health and wellbeing of Trans* and Sex and Gender Diverse people and we wish you well in your studies.

Yours sincerely,

Evie Ryder

(On behalf of MGOV)

Appendix B: Diagnostic Criteria through the DSM

Table B1

DSM-III Diagnostic Criteria for Transsexualism (302.5x)[a]

A. **Sense of discomfort and inappropriateness about one's anatomic sex**
B. **Wish to be rid of one's own genitals and to live as a member of the opposite sex**
C. **The disturbance has been continuous (not limited to periods of stress) for at least two years**
D. **Absence of physical intersex or genetic abnormality**
E. **Not due to another mental disorder, such as Schizophrenia**

Note. Reproduced from DSM-III (American Psychiatric Association, 1980).
[a] The "x" in the diagnostic criteria for transsexualism refers to sexual subtypes: 1 = asexual, 2 = homosexual, 3 = heterosexual and 0 = unspecified and is based on prior sexual history

Table B2

DSM-III-R Diagnostic Criteria for Transsexualism (302.50)[a]

A. **Persistent discomfort and inappropriateness about one's anatomic sex**
B. **Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring sex characteristics of the other sex**
C. **The person has reached puberty**

Note. Reproduced from DSM-III-R (American Psychiatric Association, 1987).
[a] Specify history of sexual orientation: asexual, homosexual, heterosexual or unspecified.

Table B3

DSM-IV Diagnostic Criteria for Gender Identity Disorder in Adults (302.85)[a]

A. **A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex**
B. **Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex**
C. **The disturbance is not concurrent with a physical intersex condition**
D. **The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning**

Note. Reproduced from DSM-IV (American Psychiatric Association, 1994).
[a] Specify if sexually attracted to males, sexually attracted to females, sexually attracted to both or sexually attracted to neither.

Table B4

DSM-IV-TR Diagnostic Criteria for Gender Identity Disorder in Adults (302.85)[ab]

A. **A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex**
B. **Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex**
C. **The disturbance is not concurrent with a physical intersex condition**
D. **The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning**

Note. Reproduced from DSM-IV-TR (American Psychiatric Association, 2000)
[a] Specify if sexually attracted to males, sexually attracted to females, sexually attracted to both or sexually attracted to neither.
[b] There was no change in the criteria from the previous version.

Table B5

DSM-5 Diagnostic Criteria for Gender Dysphoria in Adolescents and Adults (302.85)[abc]

A. **A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration as manifested by at least two of the following:**
a. **A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics**
b. **A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender**
c. **A strong desire for the primary and/or secondary sex characteristics of the other gender**
d. **A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)**
e. **A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)**
f. **A strong feeling that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)**
B. **The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning**

Note. Reproduced from DSM-5 (American Psychiatric Association, 2013)
[a] Specify if with a disorder of sexual development (e.g., a congenital andrenogenital disorder)
[b] Specify if post-transition.
[c] All references to sexual orientation removed from DSM-5.

Appendix C: Copyright Permission to use Figure 1

Dr Riki Lane
Email: riki.lane@gmail.com

10/11/2015

Dear Dr Lane,

My name is Belinda Chaplin, a current member of ANZPATH. I am completing a PhD thesis at the Queensland University of Technology (QUT), Australia. In the introductory chapter, I include one section on trans* aetiology, of which your work succinctly places all the players in this area.

Theses published at QUT are made digitally available on the World Wide Web for public access via the QUT ePrints database. See URL: http://eprints.qut.edu.au/

My thesis includes the following copyright material:

Figure 6.1 Major figures and participants in constructed positions (p. 190)

from the following works for which you hold the copyright:

Trans, science and society: The politics of knowledge of the brain sex theory of trans (Thesis)

I wish to seek from you a limited, non-exclusive licence, for an indefinite period to include these materials for which you hold the copyright, in the digital copy of my thesis to be made available on QUT ePrints. Your works will of course be fully and correctly referenced. I understand if you do not wish to give permission, and it will not appear in the digital copy of the thesis if this is the case.

Please sign below if you agree, scan and return to me via email at your earliest convenience.

I (print name) RIKI LANE agree to permit the non-exclusive licence for an indefinite period to include the above materials for which I am copyright owner, into your thesis for inclusion in QUT ePrints.

Position RESEARCH FELLOW, MONASH UNIVERSITY
Date 12 NOV 2015

Signature

Yours sincerely,

Belinda Chaplin
10/11/2015

12/11/2015

Appendix D: Interview Format

Item	Detail	Complete
Introductions	• Welcome and rapport building	
	• Explain my interest in the subject	
	• Answer any questions on my disclosure	
Consent (if not already obtained)	Go through consent form ensuring that:	
	• Understands what the project is about	
	• Meets the criteria of the project	
	• Understands the voluntary nature of participation and the right to withdraw	
	• Understands their involvement in the research	
	• Is informed of any potential risks and benefits	
	• Understands what will happen with the information gathered	
	• Understands complaint mechanisms in place	
	• Have participant sign consent form	
List of Organisations	• Provide list of organisations	
Demographic Information	• Complete Demographic Profile	
Tape Record	• Turn on and test	
The interview **Scenario 1 (YES)** [89]	• Some people find it helpful to express their thoughts and feelings by using quick sketches or drawings. There is no judgment of your artistic ability associated with this part of the interview. For example, you can use "stick people" in your representation. Would you like to try this? • I want you to think about the final transition from your assigned gender to your preferred gender. I'd like you to remember the time when you found out that having the surgery was finally going to be a reality, going through the surgery, and the postoperative period as you adjusted to your new lifestyle. I'd like you to draw one or more pictures that describe how you experienced "the change" [90] – what was "the change" like for you? • Let's have a closer look together at your drawing/s. Can you explain what your picture/s mean and how they depict your experience of "the change"? What is the story behind your picture/s? • Can you add a title to the drawing? In a few words, can you write what your picture means to you? Do this as if you were describing your picture to someone who cannot see the picture. What is most significant about the picture?	
Scenario 2 (NO)	• That's okay – we will go on with the interview then. • I want you to think about the final transition from your	

[89] The participant was provided with an A3 sketch pad and a set of 18 coloured markers with which to draw their picture/s.
[90] "The change" is a colloquial term used by transsexuals.

	assigned gender to your preferred gender. I'd like you to remember the time when you found out that having the surgery was finally going to be a reality, going through the surgery, and the postoperative period as you adjusted to your new lifestyle. I'm interested in hearing your thoughts feelings and experiences, so let me start by asking you: Can you describe how you experienced "the change" – what was the change like for you?	
Possible follow up questions[91]	1. Can you describe what you experienced at the time you received the approval to have sex reassignment surgery? 2. What types of guidance did you receive during the waiting period before the surgery? 3. What types of information did you receive from health professionals before you went to hospital for the surgery? 4. Can you describe your stay in hospital? 5. What types of information did you receive from health professionals during your stay in hospital? 6. Can you tell me about your experiences following receiving approval up until you were discharged from hospital? 7. What types of support did you receive after being discharged? Describe how your needs were met. 8. What types of follow up sessions did you have following discharge from hospital and who were they with? 9. Reflecting back, how would you describe your readiness to make the final transition? 10. Describe your major concerns or problems? 11. Whom/what did you find most helpful in dealing with these problems?	
Closing the Interview		
Questions	I think that brings us to the end of the interview. How are you feeling?	
	How do you feel about your descriptions of your journey?	
	Is there anything else about your story that you would like to share?	
Follow Up	Would you mind if I need to ask any further questions to give you a call?	
Thank You	Stop Recording	

[91] Please note: This is an indicative question list. In the tradition of narrative inquiry as a methodology, the initial question initiates a biographical narration from the participant. The probe questions in this list may change slightly depending upon the attributes of the individual participants' responses, which may require different follow-up questions. Furthermore, the questions may not be needed at all.

Appendix E: Trans* Support Organisations for Recruitment

- A Gender Agenda
- Ausgender
- Australian Transgender Support Association of Queensland Inc. (ATSAQ)
- Canberra Transgender Network
- Chameleon Society
- Freedom Centre
- Gender Centre
- Gender Menders: Social Outreach of the Gender Identity Awareness Association
- Many Genders One Voice
- Queensland Association of Healthy Communities
- South Australian Transsexual Support (SATS)
- Transgender Victoria Inc.
- Trans Health Australia
- Twenty 10
- Working it Out

Appendix F: Transsexual Types (MTF) According to the Sex Orientation Scale

PROFILE	TYPE-4[a] TRANSSEXUAL	TYPE-5[a] TRUE TRANSSEXUAL	TYPE-6[a] TRUE TRANSSEXUAL
GENDER FEELING	Non-surgical Undecided – wavering between TV and TS "Dresses" as often as possible with insufficient relief of his gender discomfort May live as a man or a woman; sometimes alternating	Moderate Intensity Feminine – Female trapped in a male body Lives and works as a woman if possible Insufficient relief from dressing	High Intensity Feminine – total psycho sexual inversion May live and work as woman "Dressing" gives insufficient relief Gender comfort intense
CONVERSION OPERATION	Attractive, but not requested or attraction not admitted	Requested – usually indicated	Urgently requested and usually attained – indicated
ESTROGEN MEDICATION	Needed for comfort and emotional balance	Needed as substitute for or preliminary to operation	Required for partial relief
PSYCHOTHERAPY	Only as guidance; otherwise refused or unsuccessful	Rejected – useless as to cure Permissive psychological guidance	Psychological guidance or psychotherapy for symptomatic relief only
REMARKS	Social life dependent upon circumstances	Operation hoped for and worked for – often attained	Despises his male sex organs Danger of suicide or self-mutilation, if too long frustrated

Note. Reproduced from "The Transsexual Phenomenon". (Benjamin, 1966)
[a] Types I, II and III (not reproduced here) refer to categories determined by Benjamin in reference to transvestites.

Appendix G: Introductory Email

Dear [**Recipient Name**]:

My name is Belinda Chaplin and I am undertaking my Doctor of Philosophy program at Queensland University of Technology (QUT).

The focus of my research project over the next two years will be an exploration of the perceptions of psychosocial experiences as they relate to the surgical processes for postoperative trans* and gender diverse people. The purpose of this qualitative study is to increase understanding of these processes and to inform professional practice for the special needs of this diverse population. My interest in trans* health results from my own background as a postoperative transwoman.

I previously completed my Honours program at QUT in 2011 on a research project which explored the psychosocial impacts of sex reassignment surgery on a small cohort of Queensland trans*people on their daily life and social functioning.

At this stage of the program, I am seeking access to organisations such as yours that may be able to help me in the recruitment process and to request that you forward the attached documents within your networks.

You can be assured that I am ethically bound to treat any information I may receive from any participant with total confidentiality/anonymity. I have obtained ethical approval for this project from QUT as part of their requirements (Approval Number 1200000502).

If you would like to assist me in this important area of research or to ask further questions, please contact me on 07 3138 3880 or via email: b1.chaplin@qut.edu.au. I look forward to hearing from you.

Thank you, and kind regards.

Belinda

Belinda Chaplin RN, BN(Hons1 QUT), ADA(Comm.Serv) | PhD Candidate: n6324312 | Sessional Academic: Research Assistant: Post Graduate Student Representative: School of Nursing (SON) | Member: Institute of Health and Biomedical Innovation (IHBI) | Member: Sigma Theta Tau International Honor Society (STTI) | Member: World Professional Association for Transgender Health (WPATH) | Member: Australian and New Zealand Professional Association for Transgender Health (ANZPATH) | Ph: 07 3138 3880 | N412a Kelvin Grove Campus | PO Box 2092 Kelvin Grove Qld 4059 | b1.chaplin@qut.edu.au |CRICOS No. 00213J

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives. William A Foster (1917-1945)

I ACKNOWLEDGE AND PAY RESPECT TO THE TURRBAL, JAGERA/YUGGERA, KABI KABI AND JINIBARA PEOPLES ON WHOSE LAND I WALK AND WORK.

Appendix H: Recruitment Email

Dear Colleagues and Friends,

My name is Belinda Chaplin from the School of Nursing at QUT Kelvin Grove, and I am undertaking a research project as part of my Doctor of Philosophy program where I am exploring the perceptions of psychosocial experiences of postoperative trans* and gender diverse people as they relate to the surgical transition from one gender to their preferred gender.

The field of trans* and gender diverse health and wellbeing is constantly evolving and the needs of this rare population are often misunderstood. If you have had sex reassignment surgery and would like to help me in this study, or know somebody who would like to help, I am looking for postoperative trans* and gender diverse people over the age of 18 to talk about their experiences.

Details on the study and how to participate are attached. If you would like to participate or want any information, please contact me, Belinda Chaplin, on (07) 3138 3880 or email me at b1.chaplin@qut.edu.au.

All participants will receive $20 to assist with out-of-pocket expenses such as travel and parking. It should also be noted that this research project has been approved by the QUT Human Research Ethics Committee (Approval Number 1200000502).

I look forward to your response. Please do not hesitate to contact me if you want any more information.

Cheers, and kind regards,

Belinda

Belinda Chaplin RN, BN(Hons1 QUT), ADA(Comm.Serv) | PhD Candidate: n6324312 | Sessional Academic: Research Assistant: Post Graduate Student Representative: School of Nursing (SON) | Member: Institute of Health and Biomedical Innovation (IHBI) | Member: Sigma Theta Tau International Honor Society (STTI) | Member: World Professional Association for Transgender Health (WPATH) | Member: Australian and New Zealand Professional Association for Transgender Health (ANZPATH) | Ph: 07 3138 3880 | N412a Kelvin Grove Campus | PO Box 2092 Kelvin Grove Qld 4059 | **b1.chaplin@qut.edu.au** |CRICOS No. 00213J

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives. William A Foster (1917-1945)

I ACKNOWLEDGE AND PAY RESPECT TO THE TURRBAL, JAGERA/YUGGERA, KABI KABI AND JINIBARA PEOPLES ON WHOSE LAND I WALK AND WORK.

Appendix I: Recruitment Flyer – Final Version

Queensland University of Technology
Brisbane Australia

PARTICIPATE IN RESEARCH

Information for Prospective Participants

The following research activity has been reviewed via QUT arrangements for the conduct of research involving human participation.
If you choose to participate, you will be provided with more detailed participant information, including who you can contact if you have any concerns.

"Exploring Post-Operative Trans and Gender Diverse Peoples' Perceptions of Psychosocial Experiences Surrounding the Surgical Process"*

Research Team Contacts

Principal Researcher:	Belinda Chaplin	– Doctor of Philosophy Candidate
Associate Researchers:	Dr Leonie Cox	– Principal Supervisor
	Dr Christina Campbell	– Associate Supervisor
	School of Nursing – Faculty of Health – Queensland University of Technology	

Please contact the research team members to have any questions answered or if you require further information about the project.

What is the purpose of the research?

From a medical perspective, Gender Dysphoria (GD) is a condition where an individual has a marked incongruence between their expressed/experienced gender and their assigned gender. One recognised treatment for some individuals diagnosed with the condition is sex reassignment surgery (SRS). The purpose of this research is to gain a better understanding of the thoughts, feelings and experiences of trans* and gender diverse people who have undergone sex reassignment surgery and the processes involved in coping with a life changing event.

Are you looking for people like me?

The research team is looking for trans* and gender diverse people over 18 years of age, who are fluent in English, and have undergone sex reassignment surgery at least 6 months ago who are willing to talk about their experiences.

What will you ask me to do?

Your voluntary participation will involve being interviewed by a research team member. The interviewer will ask you questions about your experiences in transitioning from one gender to another. The face-to-face interview will take place at QUT or other agreed venue, and is expected to take about 60 minutes.

Are there any risks for me in taking part?

The research team has identified the following possible risks in relation to participating in this study – anxiety and emotional discomfort.

Strategies are in place to manage these risks and full details will be provided should you choose to participate. However, it should be noted that if you do agree to participate, you can withdraw from participation during the project without comment or penalty.

Are there any benefits for me in taking part?

It is expected that this project will not benefit you directly. However, it may benefit other trans* and gender diverse people in the future by improving knowledge and understanding of the needs of people undergoing sex reassignment surgery.

Will I be compensated for my time?

We would very much appreciate your participation in this research. To compensate you for your contribution, should you choose to participate, the research team will provide you with out-of-pocket expenses of $20.

I am interested – what should I do next?

If you would like to participate in this study, please contact Belinda Chaplin on (07) 3138 3880 or via email: b1.chaplin@qut.edu.au for details of the next step. You will be provided with further information to ensure that your decision and consent to participate is fully informed.

Thank You!

QUT Ethics Approval Number: 1200000502

Appendix J: Participant Information Sheet – Final Version

QUT Queensland University of Technology Brisbane Australia

PARTICIPANT INFORMATION FOR QUT RESEARCH PROJECT
– Interview –

"Exploring Post-Operative Trans and Gender Diverse Peoples' Perceptions of Psychosocial Experiences Surrounding the Surgical Process"*

QUT Ethics Approval Number 1200000502

RESEARCH TEAM

Principal Researcher: Belinda Chaplin – Doctor of Philosophy Candidate

Associate Researchers: Dr Leonie Cox – Principal Supervisor

Dr Christina Campbell – Associate Supervisor

School of Nursing – Faculty of Health – Queensland University of Technology (QUT)

DESCRIPTION

This project is being undertaken as part of a Doctor of Philosophy degree for Belinda Chaplin within the School of Nursing, QUT.

The purpose of this project is to gain a better understanding of the thoughts, feelings and experiences of trans* and gender diverse people who have undergone sex reassignment surgery and the processes involved in coping with a life changing event.

You are invited to participate in the project because you may contribute to better care options of trans* and gender diverse people undergoing sex reassignment surgery in Australia.

PARTICIPATION

In order to participate, you will need to:

- **Be over 18 years of age**
- **Be fluent in English**
- **Have undergone sex reassignment surgery at least 6 months ago, and**
- **Be able to give informed consent**

Your participation will involve an **audio recorded interview** at QUT in a private office or other agreed location (such as a library or public meeting room) that will take approximately one **hour of your time**. Possible questions may include:

- Can you describe what you experienced at the time you received the approval to have sex reassignment surgery?
- What types of guidance did you receive during the waiting period before the surgery?
- Can you tell me about your experiences following receiving approval up until you were discharged from hospital?
- What types of support did you receive after being discharged?

Your participation **may involve a second audio recorded interview** which may be conducted via electronic media such as Skype or Facetime. However, you will be under **no obligation** to participate in this second interview.

Your participation in this project is entirely **voluntary**. If you do agree to participate, you can **withdraw** from the project without comment or penalty. Your decision to participate or not participate will in no way impact upon your current or future relationship with QUT (for example, your options of becoming involved in future research projects or training activities, your working relationship with the university, or your grades as a student).

EXPECTED BENEFITS

It is expected that this project will not benefit you directly. However, it may benefit other trans* and gender diverse people in the future. Your contribution may help to improve knowledge and understanding, which might potentially lead to better care options and improve the health and wellbeing for a population that has its own special needs.

To compensate you for your contribution, should you choose to participate, the research team is providing participants $20 to help cover out-of-pocket expenses such as travel and parking.

RISKS

There are minimal risks associated with your participation in the project. It is acknowledged that participation in this project may cause you to feel emotional discomfort during the interview. This anxiety may be the result of the interview or related to past events. If this happens, the interview will be stopped to allow you to regain your composure or completely terminated if you choose.

QUT provides for limited free counselling for **Brisbane based** research participants of QUT projects who may experience discomfort as a result of their participation in the research. Should you wish to access this service please contact the Clinic Receptionist of the QUT Psychology Clinic on 07 3138 0999. Please indicate to the receptionist that you are a research participant.

Independent support and counselling services are also available throughout Australia. A list of these organisations is provided to you (see attached).

PRIVACY AND CONFIDENTIALITY

All comments and responses will be treated confidentially. The names of individual persons are not required in any of the responses. As the interview involves audio recording, the following information will apply:

- The audio recording will be destroyed at the end of the project.
- In order to respect your anonymity and confidentiality, only members of the research team will have access to the audio recording and the data obtained during the project. Additionally, only the principal researcher will transcribe the audio recording. No external transcriber will be used.
- It is not possible to participate in the project without being audio recorded.
- Your responses will not be verified with you prior to inclusion in the final document.

Please note that non-identifiable data collected in this project may be used as comparative data in future projects or stored on an open access database for secondary analysis.

CONSENT TO PARTICIPATE

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate.

QUESTIONS / FURTHER INFORMATION ABOUT THE PROJECT

If have any questions or require any further information please contact one of the research team members below.

Belinda Chaplin	07 3138 3880	b1.chaplin@qut.edu.au
Dr Leonie Cox	07 31383877	leonie.cox@qut.edu.au

CONCERNS / COMPLAINTS REGARDING THE CONDUCT OF THE PROJECT

QUT is committed to research integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Unit on 07 3138 5123 or email ethicscontact@qut.edu.au. The QUT Research Ethics Unit is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

Thank you for helping with this research project. Please keep this sheet for your information.

Appendix K: Consent Form – Final Version

Queensland University of Technology
Brisbane Australia

CONSENT FORM FOR QUT RESEARCH PROJECT
– Interview –

"Exploring Post-Operative Trans and Gender Diverse Peoples' Perceptions of Psychosocial Experiences Surrounding the Surgical Process"*

QUT Ethics Approval Number 1200000502

RESEARCH TEAM CONTACTS

Belinda Chaplin – PhD Candidate
School of Nursing – Faculty of Health QUT
07 3138 3880 b1.chaplin@qut.edu.au

Dr Leonie Cox – PhD Supervisor
School of Nursing – Faculty of Health QUT
07 3138 3877 leonie.cox@qut.edu.au

STATEMENT OF CONSENT

By signing below, you are indicating that you:

- Have read and understood the information document regarding this project.
- Have had any questions answered to your satisfaction.
- Understand that if you have any additional questions you can contact the research team.
- Understand that you are free to withdraw without comment or penalty.
- Understand that you can contact the Research Ethics Unit on 07 3138 5123 or email ethicscontact@qut.edu.au if you have concerns about the ethical conduct of the project.
- Understand that the project will include audio recording.
- Understand that any drawings created become the property of the researcher.
- Understand that non-identifiable data collected in this project may be used as comparative data in future projects.
- Understand that you will receive $20 to participate in this project to help cover out-of-pocket expenses.
- Agree to participate in the project.

Name _____

Signature _____

Date _____

Please return this sheet to the investigator.

Appendix L: Demographic Profile

Demographic Profile

Interview Number:

Chosen Pseudonym:

Gender:

- Male
- Female
- Other (please specify).....

Age: Year of Surgery:

Living Arrangements:

- Alone
- With spouse/partner
- With others
- Other (eg. Homeless).....

Ethnicity/Nationality:

Employment Status:

- Paid Employment
- Self Employed
- Unemployed
- Retired
- Other (eg. Student).....

Marital Status:

- Married
- Divorced/separated
- Widowed
- Single
- De Facto

Highest Education Achieved.....

Appendix M: Trans* Support Services – Nationwide Listing

Should you experience any discomfort as a result of the interview, or require any further information or support related to your gender or health, please refer to below services available throughout Australia.

Lifeline (Nationwide)
Website: www.lifeline.org.au
Phone: 131 114

Gender Centre (NSW and Nationwide)
Address: 7 Bent Street, Petersham NSW 2049
Website: http://www.gendercentre.org.au/
Email: reception@gendercentre.org.au
Phone: 02 9569 2366 or 1800 069 115
The Gender Centre offers a wide range of services to people with gender issues, their partners, families and friends in New South Wales.
Services include: Counselling, residential support, case management, advocacy, training and education, and social support.

Twenty 10 (NSW)
Address: 45 Bedford Street, Newtown NSW 2042
Website: http://www.twenty10.org.au/
Phone: 02 8594 9555 or Free Call: 1800 65 2010.
Twenty10 is a community based service that supports and works with young people, communities and families of diverse genders, sexes and sexualities across New South Wales.
Services include: case management, counselling, accommodation, drop-in, fortnightly groups (GenderQ), community education and training.

Australian Transgender Support Association (QLD)
Website: www.atsaq.com
Email: trans.atsa@bigpond.com
Phone: 07 3843 5024
A Brisbane-based, non-profit organisation providing emotional/moral support for people with Gender identity Disorder, their families and friends.
Services include: counselling, referral and information, crisis counselling, drug and alcohol counselling for transgendered people, their families and friends.

TransGender Victoria (VIC)
Website: http://www.transgendervictoria.com/
Email: transgendervictoria@yahoo.com.au
Phone: 03 9517 6613
Transgender Victoria is dedicated to achieving justice and equity for all transgender people, their partners, friends and families.
Services include: advocacy and support on a range of issues including education, health, and accommodation and facilitating assistance with workplace issues.

Canberra Transgender Network; NewCTN (ACT)
Email: newctn@gmail.com
NewCTN is the Canberra region's social and support group network organised by Transgendered people, families and partners. NewCTN welcomes all individuals who identify as Intersex, Trans-Women, Trans-Men and Gender Queer and individuals not using descriptive labelling.

A Gender Agenda (ACT)
Email for support services: support@genderrights.org.au.
Email for advocacy services: advocacy@genderrights.org.au
A Gender Agenda provide primarily email based support and advocacy services for sex and gender diverse people.

South Australian Transsexual Support Group (SA)
Website: http://www.tgfolk.net/sites/satsg
Email: satsgroup@yahoo.com.au
Gay & Lesbian Counselling Service (Gayline) on: (08) 8422 8400 Free Call: 1800 182 233
A support group for transsexuals who have changed or are about to change their gender role and their partners. Also provides information on transsexualism for the community and people with gender identity difficulties.

Working it Out (TAS)
Website: http://www.workingitout.org.au/index.html
Email: exec@workingitout.org.au
Phone: 03 6231 1200 [Nth Hobart]
03 6334 4013 [Launceston]
03 6432 3643 [Burnie]
Helping to build individual resilience, community capacity and a more just society for gay, lesbian, bisexual, transgender and intersex community members and their friends and family.

Freedom Centre (WA)
Phone: 08 9228 0354
Website: www.freedom.org.au/
Email: info@freedom.org.au
Provides peer support services, information, referrals and a safe social space for young people (under 26) who are gay, lesbian, bisexual, transgender, transsexual, intersex, queer and questioning their sexuality or sex/gender.

Chameleon Society (WA)
Website: http://www.chameleonswa.com/
Email: chameleonswa@yahoo.com.au
A support and social group for Crossdressers, Transsexuals, their partners and other people and businesses involved with the transgender community.

Appendix N: Initial Reflections of Interviews

Interview # and Pseudonym	Reflection	Sensitising Concepts
4. Irish	I'm thinking about the determination and the temporal aspects of this interview. It was a long time from original feelings of trans* being to a final eventuation of Irish. So many different aspects of time; the time of the surgery, the years since the surgery, all those 60 years of waiting to come to a point where it was time. And as Irish said it was the right time.	Temporality Identity
5. Phoenix	I'm wondering about the differences that Phoenix presents being a person born with a DSD. I didn't know she was intersex before the interview. I mean she had her trans*ness thrust upon her at birth. I suppose that in one way you could say her destiny was something set in concrete, and I think she was lucky not to suffer a surgical fate in infancy. Maybe that part relates to her spiritual journey, the spirit leaving the body as she spoke about, and although she was born that way, which I'm thinking is easier, she had some real issues mentally associated with that. That was interesting. That was weird too when she mentioned what the surgeon said about finding a nice man because he said exactly the same thing to me.	Identity Spirituality Health Biomedicine
6. Jeremy	Wow - I've entered a new area. I know nothing about trans* men and what they go through. Issues that hit me in the face were things to do with how a girl becomes a boy. I'd never considered it before now; why would a girl want to become a boy? That seemed like a strange thing to do; turning femininity into masculinity and what type of man would Jeremy be was his take on it because he didn't like what he saw around him. I think for him non-binary is normality and that's a problem from a legal sense. He also highlighted the power of doctors and their influence; another issue we take for granted.	Stereotypes Identity Institutions Biomedicine
7. Leroy	It further hit me talking to Leroy about the physical difficulties of transition for trans* men. I remember from my transition concealment was fairly simple but it's not that simple for men like Leroy. I'd never considered how concealment was so physically demanding or just plain bad for you from a health perspective. I'm thinking about how SRS is different to trans* women because we have the lot done and they generally don't; so there's a sense of stoicism and I suppose that's the man coming out but the body tells a different story.	Health Identity
8. Jimmy	This is my third interview with a trans* man and I'm thinking about how each one of these men presents a different aspect of maleness, both physically and in attitude. Jimmy is a quiet, somewhat anxious, almost introverted man's man. But at the same time, there is the same thread occurring about the dysphoria following surgery. That's interesting.	Health Stereotypes
9. Dee Dee	I had another flashback today when Dee Dee said about what the doctor said after surgery about crying and taking what they say as being okay. What's that all about? I'm thinking about the biomedical power issue again. We let these people do what they want to us on their terms. And then there's the backflip with the same doctor saying find a man who would be gentle. It's starting to sound a bit scripted. Another legal hurdle too with gender markers.	Institutions Biomedicine Identity

10. Ms Mel	Wow that was interesting. What about that drawing of the rose and the butterfly? I'm thinking about the complexity of being trans* now and the temporal aspects of this transition again. There's another one who has taken a long time to get to where it cannot wait any longer but in a different way to Irish. Although they both fought their identity, it took a different road mentally, this time in a negative way, and there is anger in her voice.	Identity Temporality Health
11. Daniel	I'm thinking about time again. This time there was urgency and being forced to wait and a lot of tension around religious traditions and perceptions of femininity and masculinity and what it means to each of us. Is it generational those feelings of have to have it all done now? It's like they can't wait to go through normal processes like my generation.	Temporality Spirituality Identity
12. Andrew E	The issue of concealment came up again and how difficult the process can be for trans* men, and the objectivity of the biomedical model, well actually more than that; almost a total disregard for the feelings of the patient. He understands it all because of his sister being a doctor. Andrew doesn't seem to have the lower dysphoria and I'm wondering if it's his age or because he hasn't had bottom surgery yet. That's interesting. More legal issues flagged.	Biomedicine Identity Institutions
13. Buffy Dunlop	Once more I am thinking about time, not moving forward; taking the plunge; stopping and starting; getting approval and then more waiting for the surgery. Another thought about the losing of personal control to biomedicine and giving into their positions of power.	Temporality Biomedicine
14. LM	Well another trans* man who is dysphoric about his vagina and the inability to do anything about it brings about that same thread associated with time; contemplating the future; waiting; in the distance. And a different take on masculinity as well. He is more typically male with his muscly arms and upper body. In some ways it is another form of concealment; a distraction. Another thing, what about changing his gender markers?	Temporality Stereotypes Identity Health Institutions
15. John	John fits the mould of the non-binary just like Jeremy. He's happy to proclaim his trans*ness; realising that it's okay to be both male and female at some point in life. He also presents a different form of masculinity. I'm thinking maybe because the ultimate SRS is so out of reach that it's a way of coping with the reality of that.	Identity Stereotypes
16. Robert	Another interesting interview about how powerful religion is in some people's lives; so powerful that he believed that it was God's decision for him to be trans* and not his own. Also, he brought me back to the point of the health issues faced by trans* men by binding; concealing large breasts; what is that doing? Can it affect the results of SRS or doesn't it matter? Maybe just having them removed is the important thing. More stories of lower dysphoria.	Health Spirituality
17. Jim	I'm thinking about more waiting and having to go through two separate assessments because the laws in South Australia are so structured. I think the word Jim used was prescriptive. And also another lengthy time of concealing and binding. Time is a constant thread throughout.	Temporality Institutions Health

Appendix O: QUT HREC Approval Certificate

University Human Research Ethics Committee

HUMAN ETHICS APPROVAL CERTIFICATE

NHMRC Registered Committee Number EC00171

Date of Issue: 8/10/12 (supersedes all previously issued certificates)

Dear Ms Belinda Chaplin

A UHREC should clearly communicate its decisions about a research proposal to the researcher and the final decision to approve or reject a proposal should be communicated to the researcher in writing. This Approval Certificate serves as your written notice that the proposal has met the requirements of the *National Statement on Research involving Human Participation* and has been approved on that basis. You are therefore authorised to commence activities as outlined in your proposal application, subject to any specific and standard conditions detailed in this document.

Within this Approval Certificate are:

* Project Details
* Participant Details
* Conditions of Approval (Specific and Standard)

Researchers should report to the UHREC, via the Research Ethics Coordinator, events that might affect continued ethical acceptability of the project, including, but not limited to:

(a) serious or unexpected adverse effects on participants; and
(b) proposed significant changes in the conduct, the participant profile or the risks of the proposed research.

Further information regarding your ongoing obligations regarding human based research can be found via the Research Ethics website http://www.research.qut.edu.au/ethics/ or by contacting the Research Ethics Coordinator on 07 3138 2091 or ethicscontact@qut.edu.au

If any details within this Approval Certificate are incorrect please advise the Research Ethics Unit within 10 days of receipt of this certificate.

Project Details

Category of Approval:	Human non-HREC			
Approved From:	8/10/2012	**Approved Until:**	8/10/2015	(subject to annual reports)
Approval Number:	1200000502			
Project Title:	Exploring post-operative transgenders' perceptions of psychosocial experiences surrounding the surgical process			
Experiment Summary:	Gain a better understanding of the thoughts, feelings and experiences of transgender persons who have undergone SRS and the processes involved in coping with a life changing event.			

Investigator Details

Chief Investigator: Ms Belinda Chaplin

Other Staff/Students:

Investigator Name	Type	Role
Dr Leonie Cox	Internal	Supervisor
Dr Christina Campbell	Internal	Supervisor

Participant Details

Participants:
Approximately 10-15

Location/s of the Work:
QUT and other venues as appropriate

Appendix P: QUT Ethics Variation Request Approval 05/04/2013

From: QUT Research Ethics Unit
To: Belinda Chaplin
Cc: Janette Lamb
Subject: Ethics Variation -- 1200000502
Date: Friday, 5 April 2013 9:45:05 AM

Dear Ms Belinda Chaplin

Approval #: 1200000502
End Date: 8/10/2015
Project Title: Exploring post-operative trans* and gender diverse peoples' perceptions of psychosocial experiences surrounding the surgical process

This email is to advise that your variation has been considered by the Chair, University Human Research Ethics Committee.

Approval has been provided for:

< Your project to reflect the non binary and the diversity of the participant group.
< The amended title of your project.

PLEASE NOTE:
RESEARCH SAFETY -- Ensure any health and safety risks relating to this variation have been appropriately considered, particularly if your project required a Health and Safety Risk Assessment.
CONFLICTS OF INTEREST -- If this variation will introduce any additional perceived or actual conflicts of interest please advise the Research Ethics Unit by return email.

Please don't hesitate to contact us if you have any questions.

Regards

Janette Lamb on behalf of Chair UHREC
Research Ethics Unit | Office of Research
Level 4 | 88 Musk Avenue | Kelvin Grove
p: +61 7 3138 5123
e: ethicscontact@qut.edu.au
w: http://www.research.qut.edu.au/ethics/

Appendix Q: QUT Ethics Variation Request Approval 08/07/2013

From: QUT Research Ethics Unit
To: Belinda Chaplin
Cc: Janette Lamb
Subject: Ethics Variation -- 1200000502
Date: Tuesday, 9 July 2013 11:31:50 AM

Dear Ms Belinda Chaplin

Approval #: 1200000502
End Date: 8/10/2015
Project Title: Exploring post-operative trans* and gender diverse peoples' perceptions of psychosocial experiences surrounding the surgical process

This email is to advise that your variation has been considered by the Chair, University Human Research Ethics Committee.

Approval has been provided for the amended recruitment flyer.

PLEASE NOTE:
RESEARCH SAFETY -- Ensure any health and safety risks relating to this variation have been appropriately considered, particularly if your project required a Health and Safety Risk Assessment.
CONFLICTS OF INTEREST -- If this variation will introduce any additional perceived or actual conflicts of interest please advise the Research Ethics Unit by return email.

Please don't hesitate to contact us if you have any questions.

Regards

Janette Lamb on behalf of Chair UHREC
Research Ethics Unit | Office of Research
Level 4 | 88 Musk Avenue | Kelvin Grove
p: +61 7 3138 5123
e: ethicscontact@qut.edu.au
w: http://www.research.qut.edu.au/ethics/

Appendix R: Withdrawal of Consent – Final Version

Queensland University of Technology
Brisbane Australia

WITHDRAWAL OF CONSENT FOR QUT RESEARCH PROJECT

"Exploring Post-Operative Trans and Gender Diverse Peoples' Perceptions of Psychosocial Experiences Surrounding the Surgical Process"*

QUT Ethics Approval Number 1200000502

RESEARCH TEAM CONTACTS

Belinda Chaplin – PhD Candidate
School of Nursing – Faculty of Health QUT
07 3138 3880 b1.chaplin@qut.edu.au

Dr Leonie Cox – PhD Supervisor
School of Nursing – Faculty of Health QUT
07 3138 3877 leonie.cox@qut.edu.au

I hereby wish to WITHDRAW my consent to participate in the research project named above.

I understand that this withdrawal WILL NOT jeopardise my relationship with Queensland University of Technology.

Name _____

Signature _____

Date _____

Appendix S: Record of Interviews

NO.	DATE	PARTICIPANT PSEUDONYM	INTERVIEW LOCATION	AMOUNT PAID
1	27/03/13	Irish	QUEENSLAND	$20
2	08/04/13	Phoenix	QUEENSLAND	$20
3	03/06/13	Jeremy[92]	NEW SOUTH WALES	$0
4	04/06/13	Leroy	NEW SOUTH WALES	$20
5	06/06/13	Jimmy	NEW SOUTH WALES	$20
6	06/08/13	Dee Dee	QUEENSLAND	$20
7	31/08/13	Ms Mel	QUEENSLAND	$20
8	20/10/13	Daniel[93]	NEW SOUTH WALES	$0
9	21/10/13	Andrew E[94]	VICTORIA	$0
10	22/10/13	Buffy Dunlop	VICTORIA	$20
11	24/10/13	LM[95]	VICTORIA	$0
12	30/10/13	John	QUEENSLAND	$20
13	31/10/13	Robert	QUEENSLAND	$20
14	02/12/13	Jim[96]	QUEENSLAND	$0
	TOTAL			**$180**

[92] SMS sent 4th June 2013 re reimbursement – no reply received, assuming reimbursement not required.
[93] SMS sent 22nd October 2013 re reimbursement – reply received 23rd October 2013 – reimbursement not required.
[94] SMS sent 22nd October 2013 re reimbursement – no reply received, assuming reimbursement not required
[95] Email sent 6th November 2013 re reimbursement – reply received 6th November 2013 – no reimbursement required.
[96] Email sent 2nd December 2013 re reimbursement – reply received 2nd December 2013 – no reimbursement required.

Appendix T: Statutory Declaration re Participant Incentives

Oaths Act 1867

Statutory Declaration

QUEENSLAND
TO WIT

I, Belinda Chaplin

of 4/20 School Road Stafford in the State of Queensland

do solemnly and sincerely declare that

I am a Doctor of Philosophy Candidate at Queensland University of Technology and I have just completed the data collection phase of my project. As part of the protocol for that project, I offered $20 reimbursement to participants to cover incidental costs of travel, parking and the like.

I need to reclaim an amount of $180 from my student allocation to cover those costs and in order to do so, I need to provide IHBI Student Allocations Finance Office "receipts" of these transactions. These were cash transactions, but having participants sign their name for such payments is in breach of their anonymity and confidentiality for ethical reasons.

I kept a "Record of Interview" checklist denoting the date, participant pseudonym and amount paid to each participant. Therefore I declare that I paid a total of $180 to 9 participants out of 14. The other 5 participants did not require payment.

Payment to the participants was duly supported by my principal supervisor and approved by QUT Human Research Ethics Committee (Number 1200000502).

And I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the Oaths Act 1867.

Signature of declarant/deponent

Taken and declared before me at [Location] Brisbane.

this 4th day of December 2013

A Justice of the Peace/~~Commissioner~~ for ~~Declarations~~.

JUSTICE OF THE PEACE (QUALIFIED) QUEENSLAND Reg.No. 91447 DEPARTMENT OF JUSTICE QUEENSLAND

Appendix U: Australian Sex, Equal Opportunity and Anti-Discrimination Legislation[97]

Level of Government	Name of Legislation	What/who is protected?	Relevant Definitions
Commonwealth	Sex Discrimination Act (1984)	Men Women	a member of the male sex irrespective of age a member of the female sex irrespective of age
Commonwealth	Sex and Age Discrimination Legislation Amendment Bill (2011)	Single trans* people	nothing in Division 2 renders it unlawful to refuse to make, issue or alter an official record of a person's sex if a law of a State or Territory requires the refusal because the person is married.
Commonwealth	Sex Discrimination Amendment (Sexual Orientation Gender Identity and Intersex Status) Bill (2013)	Gender identity	the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person (whether by way of medical intervention or not), with or without regard to the person's designated sex at birth
State (Victoria)	Equal Opportunity (Gender Identity and Sexual Orientation) Act (2000)	Gender identity	the identification on a bona fide basis by a person of one sex as a member of the other sex (whether or not the person is recognised as such)— (i) by assuming characteristics of the other sex, whether by means of medical intervention, style of dressing or otherwise; or (ii) by living, or seeking to live, as a member of the other sex
State (South Australia)	Equal Opportunity Act (1984)	Chosen gender	the person identifies on a genuine basis as a member of the opposite sex by assuming characteristics of the opposite sex (whether by means of medical intervention, style of dressing or otherwise) or by living, or seeking to live, as a member of the opposite sex
Territory (ACT)	Discrimination Act (1991)	Gender identity	the identification on a genuine basis by a person of one sex as a member of the other sex (whether or not the person is recognised as such)— (i) by assuming characteristics of the other sex, whether by way of medical intervention, style of dressing or otherwise; or (ii) by living, or seeking to live, as a member of the other sex
State (Western Australia)	Equal Opportunity Act (1984)	Gender reassigned person	a person who has been issued with a recognition certificate under the Gender Reassignment Act

[97] Any references to intersex have been excluded.

		Gender history	**2000 or a certificate which is an equivalent certificate for the purposes of that Act a person has a gender history if the person identifies as a member of the opposite sex by living, or seeking to live, as a member of the opposite sex**
State (Queensland)	**Anti-Discrimination Act (1991)**	**Gender identity**	**means that the person identifies, or has identified, as a member of the opposite sex by living or seeking to live as a member of that sex**
State (New South Wales)	**Transgender (Anti-Discrimination and Other Acts Amendment) Act (1996)**	**Transgender or transgender person**	**is a reference to a person, whether or not the person is a recognised transgender person: (a) who identifies as a member of the opposite sex by living, or seeking to live, as a member of the opposite sex, or (b) who has identified as a member of the opposite sex by living as a member of the opposite sex,**
		Recognised transgender person	**includes a reference to the person being thought of as a transgender person, whether the person is, or was, in fact a transgender person. a person the record of whose sex is altered under Part 5A of the *Births, Deaths and Marriages Registration Act 1995* or under the corresponding provisions of a law of another Australian jurisdiction.**
State (Tasmania)	**Anti-Discrimination Act (1998)**	**Sexual orientation**	**means - (a)_ heterosexuality; or (b)_ homosexuality; or (c)_ bisexuality; or (d)_ transsexuality**
		Transsexual (not expressly protected)	**means a person of one sex who - (a)_ assumes the bodily characteristics of the other sex by medical or other means; or (b)_ identifies himself or herself as a member of the other sex; or**
		Gender	**(c)_ lives or seeks to live as a member of the other sex Refers to men and women**
Territory (Northern Territory)	**Anti-Discrimination Act (2011)**	**Sex**	**means men or women irrespective of age**
		Sexuality	**means the sexual characteristics or imputed sexual characteristics of heterosexuality, homosexuality, bisexuality or transsexuality**
Territory (Norfolk Island)[a]			

[a] Norfolk Island has no legislation in this area.

Appendix V: Changing Gender Markers on Birth Certificates

State/ Territory	Legislation	Marital Status	Surgery to reproductive organs required?	Criteria to Record Change
ACT	Births Deaths and Marriages Registration Amendment Act (2014) Births Deaths and Marriages Registration Act (1997)	May be married	No	(c) the person believes their sex to be the sex nominated in the application (the ***altered sex***), and— (i) has received appropriate clinical treatment for alteration of the person's sex
Northern Territory	Births Deaths and Marriages Registration Act (1996)	Must be unmarried	Yes	An adult: (a) whose birth is entered in the Register; and (b) who has undergone sexual reassignment surgery; and (c) who is not married
Queensland	Births Deaths and Marriages Registration Act (2003)	Must be unmarried	Yes	The reassignment of a person's sex after sexual reassignment surgery may be noted in the person's entry in the register of births or adopted children register only if the person is not married
Tasmania	Births Deaths and Marriages Registration Act (1999)	Must be unmarried	Yes	(1)_ An adult person - (a)_ whose birth is entered in the Register; and (b)_ who has undergone sexual reassignment surgery; and (c)_ who is not married
Victoria	Births Deaths and Marriages Registration Act (1996)	Must be unmarried	Yes	(1) An unmarried person— (a) who is 18 years or over; and (b) whose birth is registered in Victoria; and (c) who has undergone sex affirmation surgery; or (1) An unmarried person— (a) who is 18 years or over; and (b) whose principal place of residence is, and has been for at least 12 months, in Victoria; and (c) whose birth is registered in a place other than Victoria; and (d) who has undergone sex affirmation surgery—
New South Wales	Births Deaths and Marriages Registration Act (1995)	Must be unmarried	Yes	(1) A person who is 18 or above: (a) whose birth is registered in New South Wales, and (b) who has undergone a sex affirmation procedure, and (c) who is not married
Western Australia	Gender Reassignment Act (2000)[98]	Must be unmarried	Yes	(1) Where an application under section 14 relates to an adult, the Board may issue a recognition certificate if — (a) one or more of the following applies — (i) the reassignment procedure was carried out in the State; (ii) the birth of the person to whom the application relates is registered in the State; (iii) the person to whom the application relates is a resident

[98] All applications for a Recognition Certificate are made to the Gender Reassignment Board of Western Australia as stipulated under Part 2 of the Act.

				of the State and has been so resident for not less than 12 months; and (b) the Board is satisfied that the person — (i) believes that his or her true gender is the gender to which the person has been reassigned; (ii) has adopted the lifestyle and has the gender characteristics of a person of the gender to which the person has been reassigned; and (iii) has received proper counselling in relation to his or her gender identity.
South Australia	Sexual Reassignment Act (1988)[99]	Must be unmarried	Yes	(8) Where an application under this section relates to an adult, the magistrate may issue a recognition certificate if— (a) either— (i) the reassignment procedure was carried out in this State; or (ii) the birth of the person to whom the application relates is registered in this State; (b) the magistrate is satisfied that the person— (i) believes that his or her true sex is the sex to which the person has been reassigned; and (ii) has adopted the lifestyle and has the sexual characteristics of a person of the sex to which the person has been reassigned; and (iii) has received proper counselling in relation to his or her sexual identity.
Norfolk Island	(Registration of Births Deaths and Marriages Act, 1963)	Must be unmarried	Yes	(1) The reassignment of a person's sex after sexual reassignment surgery may be noted in the person's entry in the register of births only if the person is not married. (2) This division applies to the reassignment of the sex of a person whose entry in the register of births has been made under an order for adoption under the *Adoption of Children Act 1932.* (3) The reassignment of a person's sex includes noting that a person's sex is non-specific. (4) In this Division, the noting of reassignment of a person's sex means that the Registrar must have and maintain the noting of the reassignment of a person's sex but any extract or certificate of an entry in the register must show only the person's sex as reassigned not that there has been a reassignment by the Registrar.

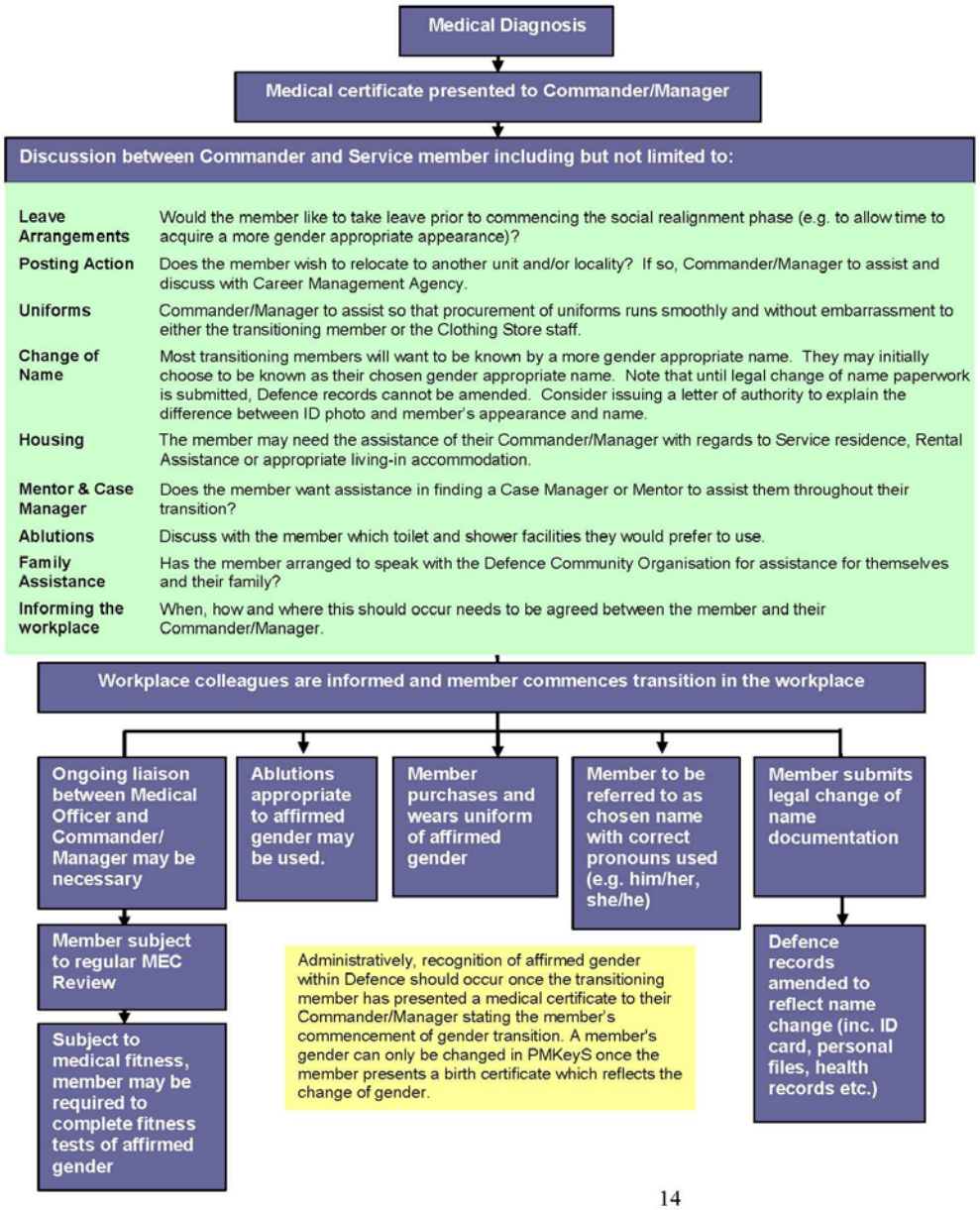
[99] All applications for a Recognition Certificate are made to The Magistrates Court of South Australia as stipulated under Part 3 of the Act.

Appendix W: Department of Defence Approach to Transition[100]

ANNEX B

ADMINISTRATION OF TRANSITIONING ADF MEMBERS

Note that the needs of every transitioning member will differ, and not every member will pass through all the phases of transition. This diagram is intended as a guide only; every member should be managed on a case-by-case basis.



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[100] This figure reproduced from *Understanding transitioning in the workplace* (Department of Defence, 2011, p. 14).